UTAH PHYSICAL THERAPY SPECIALISTS

Medical Screening Questionnaire

Name: ____________________ Date: ____________________

Please check if YOU have EVER had any of the following:

☐ Abdominal pain ☐ Allergies/asthma ☐ Diabetes ☐ Stroke ☐ Anemia
☐ Depression ☐ Circulation problems ☐ Seizures ☐ Epilepsy ☐ Heart condition
☐ High blood pressure ☐ Tuberculosis ☐ Kidney/liver disease ☐ Emphysema/Bronchitis ☐ Menstrual irregularities
☐ Thyroid problems ☐ Osteoarthritis ☐ High cholesterol ☐ Multiple sclerosis ☐ Osteoporosis
☐ Rectal bleeding ☐ Rheumatoid arthritis ☐ Chemical dependency (alcoholism, drugs etc.) ☐ Hepatitis
☐ HIV/Blood Disorder ☐ Cancer – What kind? ______________ ☐ Pacemaker ☐ Other: _____________

Please check if YOU are CURRENTLY experiencing:

☐ Changes in appetite ☐ Difficulty swallowing ☐ Weakness/fatigue ☐ Change in bowel function ☐ Headaches
☐ Poor balance/falls ☐ Dizziness/lightheadedness ☐ Fevers/chills/sweats ☐ Change in bladder function ☐ Increased pain at night
☐ Nausea/vomiting ☐ Shortness of breath ☐ Recent change in health ☐ Depression ☐ Fainting
☐ Numbness/tingling ☐ Unexplained weight loss/gain ☐ Other ______________________________

Please check if anyone in your IMMEDIATE FAMILY (parents, brothers, sisters) has EVER had any of the following:

☐ Diabetes ☐ Stroke ☐ Anemia ☐ Alcoholism (chemical dependency)
☐ Tuberculosis ☐ Kidney disease ☐ Headaches
☐ Heart Disease ☐ Cancer ☐ Epilepsy
☐ High blood pressure ☐ Arthritis ☐ Mental illness

During the past month:

1. Have you been bothered by little interest or pleasure in doing things? ☐ yes ☐ no
2. Have you been depressed, feeling down, or hopeless? ☐ yes ☐ no
3. Have you been under any abnormal stress? If yes, describe. ☐ yes ______________________________ ☐ no

How many packs of cigarettes do you smoke a day? ________ How long have you been smoking? ___________________________

How many caffeinated coffee or caffeine containing beverages do you drink per day? ______________________________________

How many days per week do you drink alcohol? __________ If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _________

Do you exercise on a regular basis? ☐ yes ☐ no What type? ____

Women: Are you (or could you possibly be) pregnant? ☐ yes ☐ no

Have you had Home Health Physical Therapy for this condition? ☐ yes ☐ no Date completed:____________________

List any prescription medications you are currently taking (with dosages):____

____

List any OVER-THE-COUNTER medications you are currently taking (with dosage):

____

List surgeries you have had including the date(s): ____

____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

____

____

Have you recently had any of the following for the condition we are treating? (Check all that apply) If yes, list the location: _________

☐☐ X-Rays ☐ MRI ☐ CT SCAN ☐ Spinal Injection ☐ Nerve Conduction Study ☐ Other _______________

When did your current symptoms begin? ____________________Does an attorney represent you for this condition? ☐ yes ☐ no

What makes your symptoms worse? ____

What makes your symptoms better? ____

My symptoms are (check one): ☐ Getting better ☐ ☐ About the same ☐☐ Getting worse

How many episodes of this specific problem have you had in the past? ____________ ☐ None

Circle if you have special learning/communication needs: Vision Hearing Language Cultural Religious Other: _________

Circle your preferred learning method(s). Written Visual Verbal Demonstration All

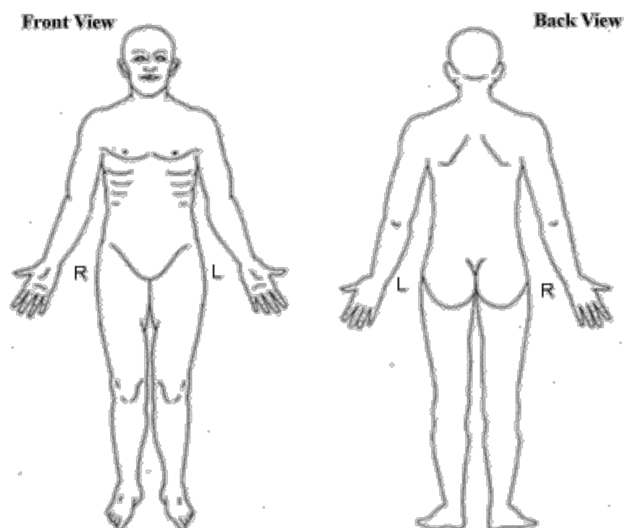
Please list the 2-3 most important **activities** you would like us to help you return to?

____

____

After you have completed your physical therapy for this condition, do you have other conditions that you would like us to help you with? ☐ Yes ☐ No If yes, please list: ____

On the diagram below, please use the following symbols to indicate the location and nature of your symptoms.
Stabbing ///// Deep ache zzzzz Pins and needles 0000 Burning xxxx Numbness ---- Other . . . . .



To the best of my knowledge, the information on this form is correct.

Patient signature: ____ Date: ___________________________