



Medical Screening Form

Briefly describe the history of your current condition: _____

Date of onset: _____

Have you received any other treatments for your current condition? _____

Have you received the following? MRI X-ray CT Scan Other: _____

List (or supply a copy) of all medications you are currently taking: _____

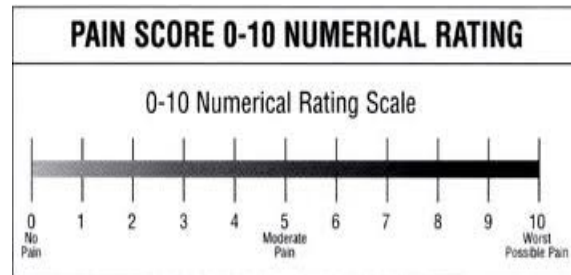
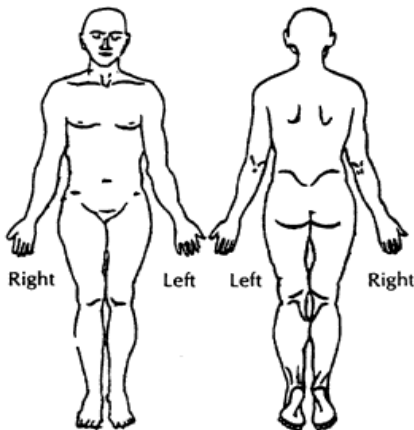
List all major surgeries: _____

Have you ever had physical therapy before? Yes No When? _____

Type of work? _____

Retired Student Full-time Part-time Light Duty Off Work

List all activities you have difficulty performing: _____



Are your symptoms: Getting Better Staying the Same Getting Worse

How are you able to sleep at night? Good Moderate Difficulty Poor

Indicate if you have had a history of any of the following conditions:

- | | | |
|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Circulatory Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizziness/Fainting |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Liver/Kidney Disease | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Lung Condition | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Herniated Disk |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Fractures | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Joint Replaced |