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?_____

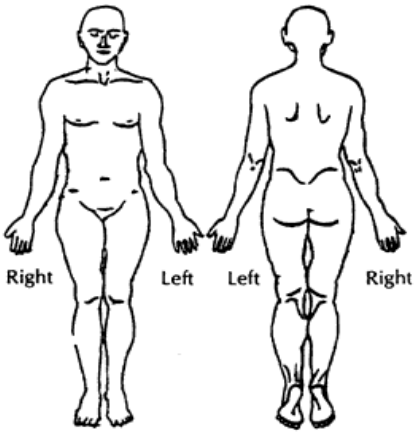
Type of work?_____

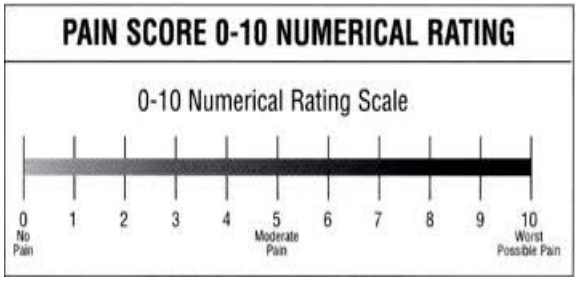
☐ Retired ☐ Student ☐Full-time ☐Part-time ☐Light Duty ☐Off Work

List all activities you have difficulty performing: _____

_____

On a scale 0-10, where 0 is no pain at all and 10 means you need to go to the E.R., rate your pain you are currently in and mark on the body pain location(s):





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:

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