Sitka Physical Therapy Medical Screening Questionnaire

Date: ______________ DOB: ___/___/_____

Name: _______________________________

Gender: M F Smoker: Y N

Pregnant: Y N Workers Comp: Y N

Occupation:__________________________

Recent Motor Vehicle Accident: Y N

List your regular exercise routine below:

____

____

Past Surgical History (list all and date-continue on back if needed)

____

____

____

Please list ALL current Medications:

____

____

____

Have you had any diagnostic imaging (MRI, x-ray) or blood work:

Y N: ____

Past Medical History: Please circle each condition that you have been told you have (or have had):

Cancer	Diabetes I or II	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Heart Disease	Angina/chest pain	Pace Maker	Fibromyalgia
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Corticosteriod use	Migraines
Seizures	Endometriosis	Blood clots	Allergies/asthma	Lung Disease
Ulcers	Cardiac Disease	Vascular Disease	Stroke/ CVA	Anticoagulant Therapy

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Current Medical History: Have you RECENTLY noted any of the following (circle all that apply)?

Fatigue	Numbness or tingling	Constipation	Fever/chills/sweats	Muscle weakness
Diarrhea	Nausea/vomiting	Shortness of breath	Weight loss/gain	Fainting
Falls	Difficulty swallowing	Headaches	Heartburn/indigestion	Cough
Changes in bowel or bladder function		Dizziness/lightheadedness		Recent infections
Difficulty maintaining balance while walking		Recent Dental work		

Have you seen other health care providers recently?____

Do you take blood thinners? Y N Are you allergic to Latex? Y N Other allergies:__________________

Does sneezing, coughing, or deep breathing make your pain worse? Y N ____________________________________

Do you have pelvic pain or trouble with bowel, bladder, or sexual activities/functions? Y N ____________________

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Y N

During the past month, have you often been bothered by little interest or pleasure in doing things? Y N

Please fill out the body chart and scale on the back of this form

The Patient-Specific Functional Scale

Please list three important activities that you are unable to do or have difficulty doing as a result of your current pain or injury. Your PT will go over the score with you later.

ACTIVITY	TODAY'S SCORE		
1.			
2.			
3.			

Directions: On the body chart below, please mark the areas of your symptoms as they are feeling today with the symbols below.

XXX Pain
/// Numbness/tingling
← Shooting pains

Other descriptors:_________________________