Advanced Rehab, PC — MEDICAL SCREENING FORM

Name: _____ **Date:** _____

Referral Source: _____

Circle Yes or No

Have you or your immediate family member ever been told you have:

	Self	Family
Cancer?	yes/no	yes/no
Diabetes	yes/no	yes/no
High Blood Pressure	yes/no	yes/no
High Cholesterol	yes/no	yes/no
Angina	yes/no	yes/no
Chest Pain	yes/no	yes/no
Stroke	yes/no	yes/no
Osteoporosis	yes/no	yes/no
Osteopenia	yes/no	yes/no
Osteoarthritis	yes/no	yes/no
Rheumatoid Arthritis	yes/no	yes/no
Head injury	yes/no	yes/no
Injury to neck/mid back/ Low back	yes/no	yes/no

General Questions:

Smoke yes/no
How much? _____
Drink alcohol? yes/no
How much? _____
Fever, chills, sweating yes/no
Headache yes/no
Excessive, unexplained weight gain or loss yes/no
Appetite loss, nausea, vomiting yes/no
Insomnia yes/no
Fatigue, Weakness yes/no
Irritability yes/no
Other _____

Eyes:

Blurred Vision yes/no
Double Vision yes/no
Pain yes/no
Other_____

Allergic/Immunologic:

Hay Fever yes/no
Drug Allergies yes/no
Other _____

Rheumatologic:

Joint swelling yes/no
Muscle pain or weakness yes/no
Skin rashes yes/no
Reaction to sunlight yes/no
Raynaud's phenomenon yes/no
Nail bed changes yes/no

Neurologic:

Tremors yes/no
Dizzy spells yes/no
Vertigo yes/no
Numbness/tingling yes/no
Weakness; atrophy yes/no
Radicular pain yes/no
Seizures yes/no
Loss of consciousness yes/no
Other _____

Cardiovascular:

Chest pain or discomfort yes/no
Stroke yes/no
Palpitations yes/no
Varicose veins yes/no
Peripheral edema yes/no
Fatigue, dyspnea, syncope yes/no
Other_____

Psychological:

Sleep disturbance yes/no
High stress level yes/no
Changes in personal habits, appetite yes/no
Confusion yes/no
Have you ever been told you have:
Depression yes/no
Anxiety yes/no
Bipolar disorder yes/no
Borderline personality disorder yes/no
Are you generally satisfied with your life? yes/no
Have you ever contemplated suicide? yes/no

Endocrine:

Excessive thirst yes/no
Temperature intolerance yes/no
Tired, sluggish yes/no
Cramps yes/no
Edema yes/no
Unexplained weakness, fatigue paresthesia yes/no
Carpal tunnel syndrome yes/no
Periarthritis, adhesive capsulitis yes/no

Integumentary:

Skin rash yes/no
Boils yes/no
Persistent itch yes/no
Other _____

Musculoskelital:

Joint pain yes/no
Neck pain yes/no
Back pain yes/no
Muscle pain yes/no
Other _____

Ear/Nose/Throat/Mouth:

Ear infection	yes/no
Sore throat	yes/no
Sinus problems	yes/no
Other _____	

Genitourinary:

Urine retention	yes/no
Painful Urination	yes/no
Frequent urination	yes/no
Incontinence	yes/no
Other_____	

Respiratory:

Wheezing	yes/no
Frequent cough	yes/no
Shortness of breath	yes/no
Pneumonia	yes/no
Pleural pain	yes/no
Clubbing	yes/no
Other _____	

Gastrointestinal:

Abdominal pain	yes/no
Indigestion; heartburn	yes/no
Difficulty swallowing	yes/no
Nausea, vomiting	yes/no
Diarrhea or constipation	yes/no
Change in bowel habits	yes/no
Rectal bleeding; blood in stool	yes/no
Skin rash followed by joint pain	yes/no
Other _____	

Hematological:

Swollen glands	yes/no
Blood clotting problem	yes/no
Skin color or nail bed changes	yes/no
Bleeding: nose, gums, easy bruising	yes/no
Hemarthrosis, muscle hemorrhage, hematoma	yes/no
Fatigue, dyspnea, weakness	yes/no
Confusion, irritability	yes/no
Headache	yes/no
Other _____	

Chief Complaint:

What is the main reason for you Physical Therapy evaluation today?

_____

List any surgeries or serious illnesses you have had and when they occurred.

Illness or Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Have you had any medical imaging done? (MRI, X-Ray, CT scan, Bone density scan)

Type of scan and part of body	Where was it done	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any other conditions that may limit your response to exercise:

Y ____ N ____ If yes, Please explain:_____

What are your hobbies/recreational activities?

_____

Have you had any recent illnesses in the past 2-3 weeks? (i.e. cold, flu, bladder infection)

Y ____ N ____ If yes, please explain: _____

Have you noticed any lumps or thickening of skin or muscles anywhere in your body?

Y ____ N ____ If yes please explain _____

Do you have any sores which haven't healed or any changes in size, shape or color of wart or mole?

Y ____ N ____ If yes please explain _____

Do you have any special needs or considerations?

Y ____ N ____ If yes please explain _____

Have you had any unexplained weight gain or loss in the past month?
Y ____ N ____ If yes please explain _____

Is there any possibility that you may be pregnant? Y ____ N ____

On a scale of 0-10 with 10 being the most severe, circle the number that best describes the pain you are having right now.
0 1 2 3 4 5 6 7 8 9 10

On a scale of 0-10 with 10 being the most severe, circle the number that best describes the pain you are having at its worst.
0 1 2 3 4 5 6 7 8 9 10

When was it last at this level?
_____

Is your pain (circle one):
Increasing decreasing staying the same

How would you describe the pain? (circle all that apply)
Constant intermittent at night In the morning

Are you experiencing any of the following? (circle all that apply):

Numbness tingling paraesthesia headaches Weakness Change in Bowel or Bladder

When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other
_____

Does anything make the problem better?
_____

How long does the problem last?
30 minute 1 hour It is always there
Other _____

Have you had physical therapy before? Y ____ N ____
What did it consist of? _____
Was it beneficial? _____

Have you tried alternative or complimentary medicine for relief? Y ____ N ____
What alternatives? _____
Were they beneficial? _____

How did you hear about Advanced Rehab?
*please check all that apply

Doctor recommendation	____	Location	____
Friend recommendation	____	Prior patient	____
Saw sign	____	Newspaper Ad	____
Internet	____	Phone Book	____
Other	____		

Please explain: _____