Physical Therapy Medical Screening Questionnaire

PANORAMA Orthopedics & Spine Center

Name: _____

Date:

Gender: M F Age:

Smoker: Y N Pregnant: Y N

Occupation:

Describe your regular exercise routine:

Past Surgical History (list all &date):

_____

_____

_____

Please List All Current Medications:

_____

_____

Have you had an x-ray, MRI, or other imaging study?

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

Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Heart Disease	Angina/Chest Pain	Ulcers	Fibromyalgia
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Pace Maker	
Allergies/Asthma	Lung Disease	Have you had a recent illness (explain if yes)? _____		

Do you take blood thinners? YES NO Are you allergic to latex? YES NO Other:

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Currently I am experiencing (circle all that apply):

Fever/chills/sweats	Poor balance (falls)		
Unexplained weight loss	Numbness or Tingling	Changes in appetite	Difficulty swallowing
Depression	Shortness of breath	Dizziness	Headaches
Changes in bowel or bladder function		Nausea /Vomiting	Increased pain at night

CURRENT SYMPTOMS

Where are you currently having symptoms? _____

What date (approximately) did your present pain start?_____

How (gradually, suddenly, injury)?_____

My symptoms are currently: **Getting better / About the same / Getting worse**

Have you received any treatment for this problem?_____

Have you ever had this problem before: **YES / NO**

If so, how was the problem treated?_____

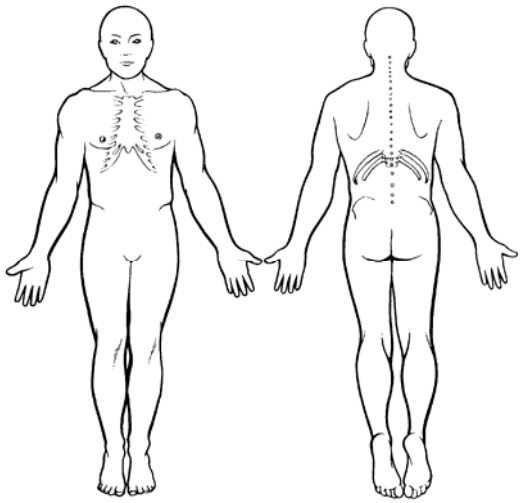
How long did it take for you to feel better? _____

How are you able to sleep at night? ☐ Fine ☐ Moderate Difficulty ☐ Only with medication

What is your personal goal for therapy? _____

TURN OVER

Body Chart:
Please mark the areas where you feel pain on the chart to the right



For the therapist
+ / - Cough/Sneeze
+ / - Saddle Anesth.
+ / - Bwl/Bldder Chnge
+ / - Numb/Ting.

On the scales below, please circle the number which best represents the severity of your pain is.

Average for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Best for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Please circle the number below which best represents your overall average level of function.

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 **Able to do everything**

What makes your symptoms better?_____

_____

Please circle the activities which make your pain worse:

lying down | sitting
walking | standing
 | stress

Any other activities that make your pain worse?:

Please list the best and worst time of day for your symptoms } Best - Worst -

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1)_____

2)_____

3)_____

Below for the Therapist:
Rating:_____
Rating:_____
Rating:_____
AVG:_____

Therapist Use

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 **Able to perform activity at same level as before your (injury or problem)**