

# Sirona Physical Therapy

## Medical Screening Form

It is important to gather information about your medical history in order to provide you with the highest quality care. Please fill out this form to the best of your knowledge. Thank you!

The information was completed accurately and to the best of my knowledge

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please check yes when appropriate.** Have you or an immediate family member ever been told you have...

**Please check if you or a family member (& whom) has had the below conditions.....**

Osteoarthritis? _____	Heart Disease? _____	Rheumatoid Arthritis? _____
Diabetes? _____	Stroke? _____	Angina/Chest Pain? _____
Cancer? _____	Osteoporosis? _____	High Blood Pressure? _____
Allergies? _____	Skin Disease/Rash? _____	Asthma? _____
Broken Bones/Fracture? _____	Blood Disorder? _____	Lung Problems? _____
Circulation/Vascular Issues? _____	Muscular Dystrophy? _____	Head Injury? _____
Low/High Blood Sugar? _____	Thyroid Problems? _____	Depression? _____
Multiple Sclerosis? _____	Kidney Problems? _____	Addiction? _____
Seizures/Epilepsy? _____	Neurologic Disorder? _____	STD? _____
Ulcers/Stomach Problems? _____	Infectious Disease? _____	Liver Problems? _____

**In the past 6 months, have you experienced...**

An overall health change? _____	Chest Pain/Angina? _____	Cough? _____
Shortness of Breath? _____	Dizziness/Fainting? _____	Weakness? _____
Coordination Problems? _____	Balance Problems? _____	Fatigue? _____
Fever/Chills/Night Sweats? _____	Nausea or Vomiting? _____	Headaches? _____
Numbness or Tingling? _____	Trouble Sleeping? _____	Hearing Issues? _____
Change in Bowel or Bladder? _____	Weight Loss or Gain? _____	Vision Problems? _____

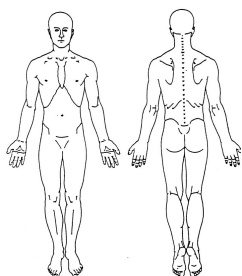
Are you currently... Under Stress? \_\_\_\_\_ Depressed? \_\_\_\_\_ Pregnant? \_\_\_\_\_

Illnesses that you have had in the past year: \_\_\_\_\_  
 Previous Surgeries (Please include dates): \_\_\_\_\_  
 Current Medications/Vitamins/Supplements: \_\_\_\_\_  
 Date of Last Physical and Name of Physician: \_\_\_\_\_

Do you drink alcohol? \_\_\_\_ How many drinks do you generally have per week? \_\_\_\_\_ Quit Date: \_\_\_\_\_  
 Have you ever smoked? \_\_\_\_ How many packs per day and for how long? \_\_\_\_\_ Quit Date: \_\_\_\_\_  
 Do you exercise? \_\_\_\_ How often? \_\_\_\_\_ Which activities? \_\_\_\_\_

What are you being seen for today? \_\_\_\_\_  
 How long has this been affecting you? \_\_\_\_\_ Is your condition improving \_\_\_\_ same \_\_\_\_ worse \_\_\_\_  
 When do you feel the best? \_\_\_\_\_ worst? \_\_\_\_\_  
 What are your goals/What would you like to be able to do? \_\_\_\_\_  
 Please list/describe anything else that you feel is important or relevant: \_\_\_\_\_

**Fill in the area of concern**



Scale: 0 is no pain and 10 is worse pain  
 Pain at worst \_\_\_\_\_  
 Pain at rest \_\_\_\_\_

**Functional Activities:**

**Please circle the activities listed below that you perform with difficulty or discomfort as a result of your injury.**

Crouching	Kneeling	Sleeping	Balance	Feeling	Stairs	Squatting
Bending	Walking	Pulling	Carrying	Cough/Sneeze	Pushing	Standing
Grasping	Reaching	Stooping	Crawling	Handling	Sitting	Working
	Computer	Lifting				Reading

**Grooming/Activities of Daily Living/Housework:**

Brushing Teeth	Pulling on Shirt	Shoes/Socks	Using Toilet	Bathing	Shaving	Sex
Driving	Trousers/Pants	Lifting	Vacuuming	Laundry	Cleaning Tub	Making
Beds	Washing Dishes	Cooking	Sweeping	Scrubbing Floor	Mopping	Grocery
Shop						

**Recreational Activities:**

Jogging    Hiking    Bicycling    Walking    Golfing    Skiing    Aerobics    Swimming    Movies Out with Friends