



# Physical Therapy Medical Screening Questionnaire

**Date:** \_\_\_\_\_  
**Name:** \_\_\_\_\_  
**Social Sec #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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**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:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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	Sexually Transmitted Disease	
Allergies/Asthma	Lung Disease	Recent illness (explain if yes)? _____		
Do you take blood thinners? YES NO		Are you allergic to latex? YES NO		

Other: \_\_\_\_\_

**Currently I am experiencing (circle all that apply):**

Unexplained weight loss	Numbness/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 it 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? \_\_\_\_\_

Do you have any barriers to learning (if so, please list)? \_\_\_\_\_

**CONSENT:** I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered. \_\_\_\_\_ (Sign)