Aptitude Physical Therapy, LLC Medical Screening Form

Name: _____

Current Medical Problem/reason for today's visit: _____

Date of Onset for this injury/condition: _____ Have you had surgery for this injury/condition? Yes No

Have you had previous physical therapy for this condition? Yes No

When is your next appointment with your doctor?

Circle Yes or No…

Have you or any immediate family member ever been told that you have:……..	**Self**	**Family**
Cancer?……	Yes……No	Yes……No
Diabetes?……	Yes……No	Yes……No
High Blood Pressure?.	Yes……No	Yes……No
Heart Disease?……	Yes……No	Yes……No
Angina/Chest Pain?…	Yes……No	Yes……No
Stroke?……	Yes……No	Yes……No
Osteoporosis?…….	Yes……No	Yes……No
Osteoarthritis?……	Yes……No	Yes……No
Rheumatoid Arthritis?	Yes……No	Yes……No

In the past 3 months have you had or do you experience:

A change in your health?……..	Yes……No
Nausea/Vomiting?……	Yes……No
Fever/chills/sweats?……..	Yes……No
Unexplained weight change?…..	Yes……No
Numbness or tingling?……..	Yes……No
Weakness?……	Yes……No
Changes in appetite?……	Yes……No
Difficulty swallowing?……	Yes……No
Changes in bowel or bladder function?……..	Yes……No
Shortness of breath?…….	Yes……No
Dizziness?……...	Yes……No
Upper respiratory infection?…….	Yes……No
Urinary tract infection?……..	Yes……No

Circle Yes or No…

Do you have a history of:

Allergies/Asthma?……..	Yes……No
Headaches?……	Yes……No
Bronchitis?……..	Yes……No
Kidney Disease?……	Yes……No
Liver Disease?.....	Yes……No
Rheumatic Fever?……	Yes……No
Ulcers?……	Yes……No
Sexually transmitted disease?…	Yes……No
Seizures?……..	Yes……No
Blood Clots?…….	Yes……No
Circulation Problems?…….	Yes……No
Infectious disease (i.e. TB)?.....	Yes……No
Biomedical implants?.....	Yes……No

Are you currently:

Pregnant?……..	Yes……No
Depressed?……	Yes……No
Under Stress?……	Yes……No

Are you allergic to latex? YES NO

Are your symptoms: (check one)

____Getting Worse ____The same ____Improving

How are you able to sleep at night? (check one)

___Fine ___Moderate difficulty ___Only with medication

Check all that apply…

Do you have a problem with…(check all that apply)

____ Hearing ____ Vision

____ Speech ____ Communication

Do you or have you in the past smoked tobacco?

YES NO

If yes, _____ Packs per day **X** _____ Years

Last tobacco use _____

Do you drink alcoholic beverages? YES NO

If yes, how many drinks do you routinely have per week? _____/ week

Date of last physical examination _____

List medications currently taking:

_____

_____

_____

List any other health care professionals whose care you are currently under:

_____

Is there any other information that would assist us with your care?

_____

Is there anything else related to your health that we have not asked you?

_____

Patient or Guardian Signature: _____ **Date:** _____

Therapists Signature: _____ **Date:** _____

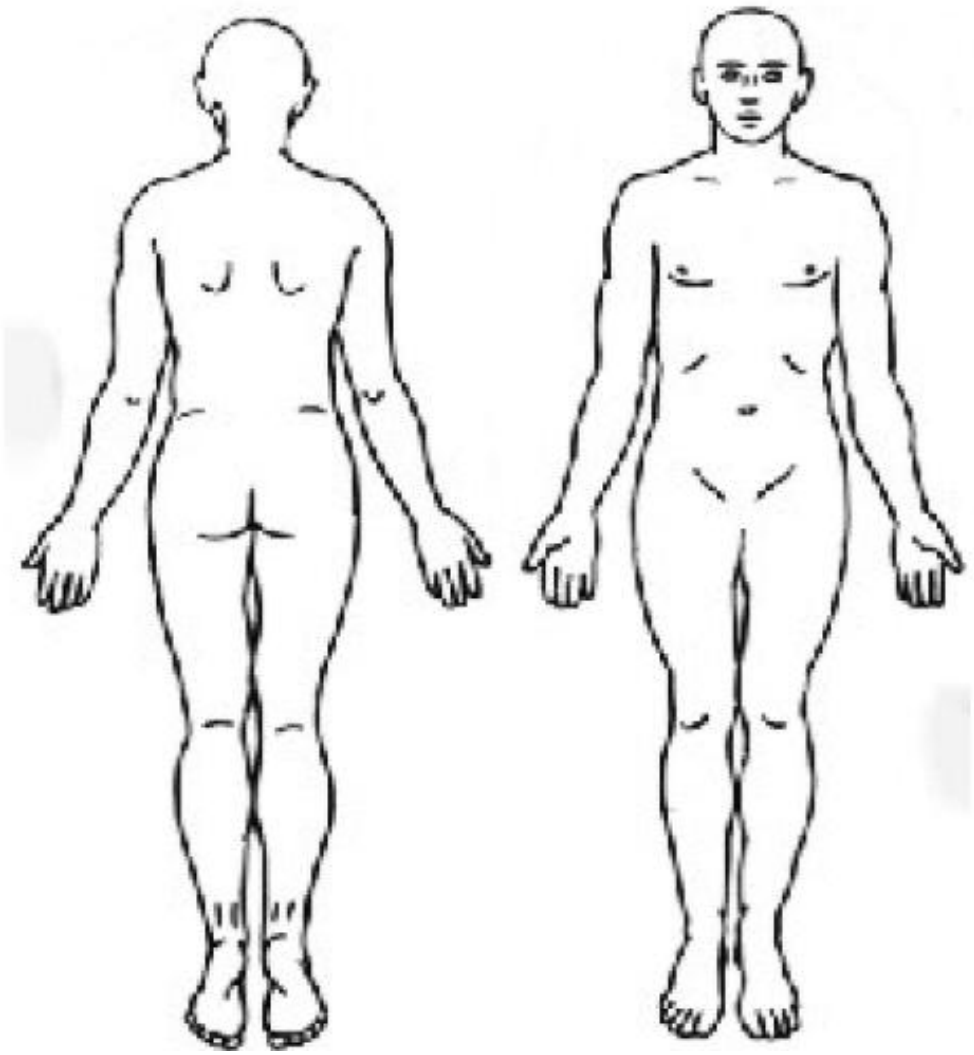
Aptitude Physical Therapy, LLC Medical Screening Form

BODY DIAGRAM

Patient's Name: _____ Date: _____

Please use the diagram below to indicate where you feel symptoms right now. Use the following key to indicate the different types of symptoms.

KEY: Pins & Needles = 00000 Stabbing = /////
Burning = XXXXX Deep Ache = zzzzz



Pain Rating: How would you rate your pain on the below scale with 0 indicating "no pain" and 10 indicating "pain as bad as it can be". Please circle the corresponding number.

Pain now:	0	1	2	3	4	5	6	7	8	9	10
Worse pain in the last week:	0	1	2	3	4	5	6	7	8	9	10
Best pain in the last week:	0	1	2	3	4	5	6	7	8	9	1