South Hills Physical Therapy Clinic

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Medical Screen

In order to ensure a thorough evaluation, please fill in this form completely. If you do not understand a question, as the therapist for assistance. Thank you.

Name: _____ **Address:** _____

Home Phone: _____ **Work/Cell phone:** _____

Occupation: _____ **Type of physical activity you perform:** _____

_____

Please describe your current condition/injury: _____

_____

_____

What do you wish to accomplish with therapy? What would you like to be able to do when you are done with therapy? _____

_____

_____

Have you seen any of the following in the last three months?

_____ Medical Doctor _____ Osteopath _____ Physical Therapist _____ Dentist
_____ Chiropractor _____ Psychiatrist/Psychologist _____ Massage Therapist

Have you or your family ever been diagnosed as having any of the following conditions?

Self	**Family Member**		**Self**	**Family Member**	
_____	_____	Asthma	_____	_____	Emphysema/Bronchitis
_____	_____	Thyroid Problems	_____	_____	Chemical Dependency
_____	_____	Multiple Sclerosis	_____	_____	Diabetes
_____	_____	Rheumatoid Arthritis	_____	_____	Arthritic Conditions
_____	_____	Depression	_____	_____	Hepatitis
_____	_____	Tuberculosis	_____	_____	Stroke
_____	_____	Kidney Disease	_____	_____	Anemia

Continued on Reverse >

_____ _____ Epilepsy _____ _____ Cancer
_____ _____ Other (Please list) _____

Are you currently pregnant? _____

Please describe any injuries for which you have been treated (fractures, dislocations, sprains, hospitalizations, etc.) including dates: _____

_____

_____

Which of the following over-the-counter medications have you taken in the last week?

_____ Aspirin _____ Advil/Motrin/Ibuprofen/Aleve _____ Tylenol
_____ Laxatives _____ Vitamin/Mineral Supplements _____ Antacids
_____ Antihistamines _____ Decongestants _____ Other (Please list)

Please list any prescription medications you are currently taking (pills, patches, injections):

_____

Have you recently noticed any of the following?

_____ Weight Loss/Gain _____ Nausea or Vomiting _____ Weakness
_____ Fatigue _____ Fever, Chills, or Sweats _____ Problems Sleeping
_____ Numbness or Tingling _____ Bowel or Bladder Problems

Do you smoke? Yes ____ No ____ If so, how many pack(s) per week? _____

How much alcohol do you consume each week? _____

_____ _____
Patient Signature **Date**

_____ _____
Therapist Signature **Date**

Form reviewed with patient? _____