LONGVIEW ORTHOPAEDIC
CLINIC ASSOCIATION

Personalized Medicine. Quality Care.

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Physical Therapy Medical Screening Questionnaire

Date: _____
Name: _____
Social Security #:__ __ __-__ __-__ __ __ __
Phone #: _____

Gender: M F Age:

Smoker: Y N Pregnant: Y N

Occupation:

Describe your regular exercise routine:

Past Surgical History (list all & the dates):

_____
_____
_____

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 -Sexually Transmitted Disease

-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
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 you 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? _____

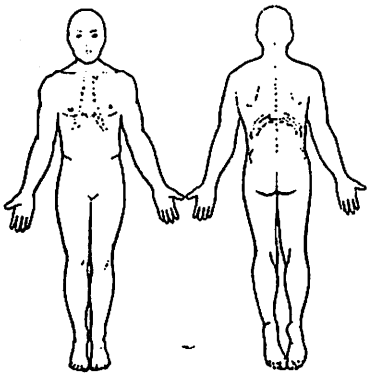
Do you have any barriers to learning, is so list? _____

_____

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**

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: sitting
lying down standing
walking 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)_____ Rating:____

2)_____ Rating:____

3)_____ Rating:____

Below for the Therapist: 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)**