323 E. Hawkins Pkwy, Suite A, Longview, TX, 75605
Ph: 903-758-2746 (Physical Therapy Ext 266)

PHYSICAL THERAPY MEDICAL SCREENING QUESTIONNAIRE

Date: __________________

Name: ____________________________

Occupation: ______________________

Age: __________

Smoker: Y N Pregnant: Y N

Recreation/Exercise:

Past Surgical History (List all & dates)

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List all Current Medications

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Have you had any of the following related to your condition?

X-Ray MRI CT Other Imaging Studies: _______________

Past Medical History/On-Going Medical Problems: Please check each condition that you have been told you have (or have had).

☐Allergies/Asthma ☐Diabetes ☐Kidney Disease ☐Stroke ☐Fibromyalgia ☐Cancer ☐High Blood Pressure

☐Heart Problems ☐Angina/Chest Pain ☐Osteoporosis ☐Ulcers ☐Circulation Problems ☐Emphysema/Bronchitis/COPD

☐ Tuberculosis ☐ Sexually Transmitted Disease ☐Rheumatoid Arthritis ☐Osteoarthritis ☐Anemia ☐ Epilepsy ☐ Hepatitis ☐ Depression ☐ Multiple Sclerosis ☐Pacemaker ☐ Blood Clotting or Bleeding Disorder

Other:____

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Currently I am experiencing (Circle all that apply): Fever/chills/sweats Poor balance (falls)

Unexplained weight loss Numbness or Tingling Change in appetite Difficulty swallowing

Dizziness Headaches Shortness of breath Increased pain at night Nausea/vomiting

Changes in bowel or bladder function

Is your condition related to: Work Sports Motor Vehicle Accident

Anything else our team should know: ____

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