

Medical Screening Questionnaire

Name: _____

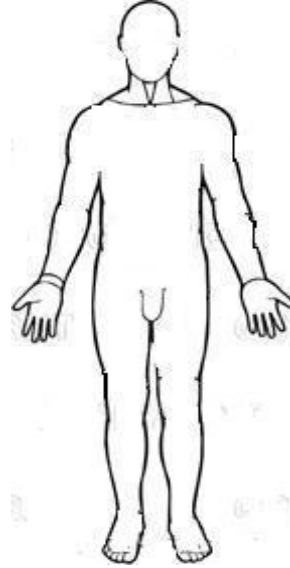
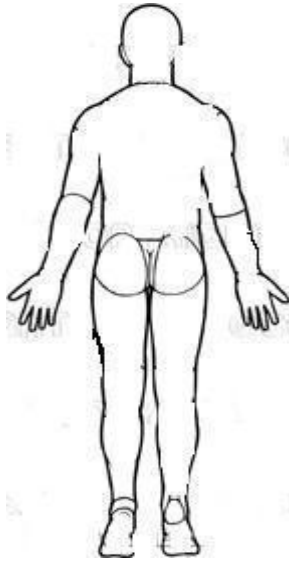
Date: _____

Age: _____ DOB: _____ Gender: _____ Weight: _____ lbs. Ideal Weight: _____ lbs.

Reason for visit: ___ Physical Therapy ___ Personal Training ___ MAT

If visit related to accident or injury, please specify: _____ Onset Date: _____

Please shade the areas that you have had symptoms:



How would you describe these symptoms? _____

Frequency of symptoms (Circle One): Constant Intermittent

If Intermittent, how often: _____

Indicate the intensity of symptoms at their best:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Indicate the intensity of symptoms at their worst:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Symptoms are worse in the: ___ Morning ___ Afternoon ___ Night
 ___ Increased during the day ___ Same all day

Have you been treated for this condition before? ___ Yes (If yes, by whom? _____) ___ No

Occupation: _____

Has your work status changed because of this condition? ___ Yes ___ No

How would you rank your level of stress? ___ High ___ Moderate ___ Low

How do you manage stress? _____

Are you currently following a special diet? ___ Yes (type: _____) ___ No

Please list any medications you are currently taking:

<u>Medication</u>	<u>Dosage / # times per day</u>	<u>For what?</u>	<u>Date started</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History

Please check if you have had any of the following conditions:

- | | | | |
|----------------------------|-------|-----------------------|-------|
| Asthma/Bronchitis | _____ | Headaches | _____ |
| Shortness of Breath | _____ | Vision difficulty | _____ |
| Coronary Heart Disease | _____ | Numbness/Tingling | _____ |
| Do you have a pacemaker | _____ | Dizziness/Fainting | _____ |
| High Blood Pressure | _____ | Weakness | _____ |
| Heart Attack/Heart Surgery | _____ | Weight/Energy Loss | _____ |
| Blood Clot/Emboli | _____ | Hernia | _____ |
| Stroke/TIA | _____ | Epilepsy/Seizures | _____ |
| Allergies | _____ | Thyroid issues | _____ |
| Pins/Metal Implants | _____ | Incontinence | _____ |
| Joint Replacement | _____ | Bowel/Bladder issues | _____ |
| Diabetes | _____ | Neck Injury | _____ |
| Rheumatic Heart Disease | _____ | Shoulder Injury | _____ |
| Cancer/Chemotherapy | _____ | Elbow/Hand Injury | _____ |
| Arthritis | _____ | Back Injury | _____ |
| Osteoporosis | _____ | Knee Injury | _____ |
| Sleeping problems | _____ | Leg/Ankle/Foot Injury | _____ |
| Do you smoke | _____ | Depression/Anxiety | _____ |
| Parkinson's | _____ | Chest discomfort | _____ |

FOR WOMEN ONLY:

- | | | | |
|-----------------------------|-------|-------------------|-------|
| Pelvic Inflammatory Disease | _____ | Endometriosis | _____ |
| Irregular Menstrual Cycle | _____ | Pelvic Pain | _____ |
| Complicated Pregnancies | _____ | Are you pregnant? | _____ |
| Any Other Health Issues? | _____ | | |

Family History:

Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset (if known) have ever been told they have:

- | | | | |
|---------------|-------|--------------|-------|
| Heart disease | _____ | Hypertension | _____ |
| Stroke | _____ | Diabetes | _____ |
| Cancer | _____ | Other | _____ |

Are you currently involved in a regular exercise program? ___ Yes ___ No

If yes, please list the activity and the frequency:

Activity	Frequency	Equipment Used:
_____	_____	_____
_____	_____	_____
_____	_____	_____

How would you rank your level of enjoyment of exercise?

High _____ Moderate _____ Low _____

Please list your personal goals:

Patient Signature _____ Date: _____

