Idaho State University

# Physical Therapy Medical Screening

**Date:____/____/____ DOB:____/____/____**

**Name:** _____

Sex: M F Age:_____ Ht:_____ Wt:_____

Smoker: Y N Possibly Pregnant? Y N

Occupation:

Briefly describe your regular exercise routine:

**Past Surgical History (please include dates if known):**

_____

_____

**Current Medications (please list or provide a list to photocopy):**

_____

_____

_____

**Recent diagnostic imaging (MRI, XR, CT) or blood work for current symptoms:**

Past Medical History: **Please 1) Put a line through any condition you have NEVER had, and 2) Circle each condition you currently have OR ever had in the past.**

Cancer Diabetes I or II Stroke Blood Clot Pacemaker Depression Seizures Ulcers
High Blood Pressure Heart Disease Liver Disease Kidney Disease Lung Disease Asthma
Fibromyalgia Osteoporosis Osteoarthritis Rheumatoid Arthritis Allergies: _____
Other(s):_____
Recent illness? (explain): _____

**Recently I have been experiencing (please circle all that apply, AND put a line through any that do not):**

| | | | | |
|---|---|---|---|---|
| Fever/Chills/Sweats | Unexplained weight loss | Increased pain at night/rest | | Difficulty swallowing |
| Difficulty speaking | Dizziness | Poor balance/Falls | Vision changes | Numbness or Tingling |
| Nausea/Vomiting | Chest Pain | Shortness of breath | Changes in appetite | Pain with meals |
| Unusual pain with menstruation | Change in (Bowel) or (Bladder) control, habits or appearance | | | |

## CURRENT SYMPTOMS

Where is your PRIMARY symptom located?_____
Approximately what date did this symptom begin? _____
How did your symptoms start (injury/gradual/sudden)?_____
Have you ever had this problem before? (circle one: **Y N** ) **If yes**, please answer the next two questions:
What treatments helped?_____
What treatments failed?_____

Please indicate any barriers to learning: _____

In the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO
In the past month, have you often been bothered by little interest/pleasure in doing things? YES NO
Are these feelings, something with which you would like help? (Yes today) (Yes but not today) (No)

I certify that the above information is correct (patient/guardian signature):_____ Date:_____
Reviewed by (physical therapist signature):_____ Date: _____