Anjoe Physical Therapy & Wellness

Medical Screening Form

Name:_______________________________________**DOB:**_________________ **Age:**______________

Height:_____________ **Weight:**____________ **Primary Care Physician:**_________________________

Your overall health right now is (circle): **Excellent** **Very Good** **Good** **Fair** **Poor**

Medical History

Please check if you recently had any of the following: Clarify responses below as needed.

□ Fatigue	□ Not feeling well	□ Change in mental function
□ Vomiting/ nausea	□ Difficulty swallowing	□ Loss of Consciousness
□ Numbness/ tingling	□ Dizziness/ light headedness	□ Any Infection
□ Fever/chills/ sweats	□ Loss of Balance/ Falls	□ Cold / Cough/ Flu
□ Weakness	□ Change in bowel/bladder function	□ Weight Change

Comments:____

Have you ever been diagnosed with any of the following conditions?

□ Cancer	□ Diabetes	□ Heart Disease
□ High Blood Pressure	□ Heart Attack	□ Angina or Chest Pain
□ Asthma	□ Tuberculosis	□ Shortness of Breath
□ Stroke	□ Pneumonia/ Bronchitis	□ Loss of Consciousness
□ Epilepsy	□ Kidney Disease/ stones	□ Urinary Tract Infection
□ Stomach aches/ nausea	□ Liver Disease / Hepatitis	□ Fatigue
□ Dizziness	□ Loss of Balance/ Falls	□ Headaches
□ Visual Disturbances	□ Head Trauma	□ Bleeding Disorders
□ Prostate problems	□ Gynecological Disorders	□ Change in ability to urinate
□ AIDS/ HIV	□ Pregnancy	□ Weight Change
□ Constipation	□ Cold / Flu / Cough	□ Thyroid Problems
□ Fever/chills/ sweats	□ Osteoporosis	□ Pacemaker
□ Weakness	□ Numbness/ tingling	□ Depression/ Anxiety

□ Metal Implant please specify:____

□ Organ Transplant please specify:____

Life Style

Do you exercise? **YES** **NO**

What types of exercise? ____

How often? ____________x/week For how many minutes?_________________________

Do you smoke tobacco? **YES** **NO** If yes, average cigarettes/day?_____________

For women: Are you currently pregnant of think you might be pregnant? **YES** **NO**

During the past month have you been feeling down, depressed or hopeless?__________

During the past month have you been feeling little interest or pleasure in doing things?________

Is this something with which you would like help? YES YES, but not today NO

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Medications

Are you currently taking any blood thinners? YES NO

Any steroids medication (Cortisone, prednisone, dexamethasone, ect.) or inhalers? YES NO

Please list your current medications with dosages: (INCLUDE: pills, injections, inhalers, and/or skin patches):____

____

____

Surgeries

Please list any surgeries that you have had and the approximate date:

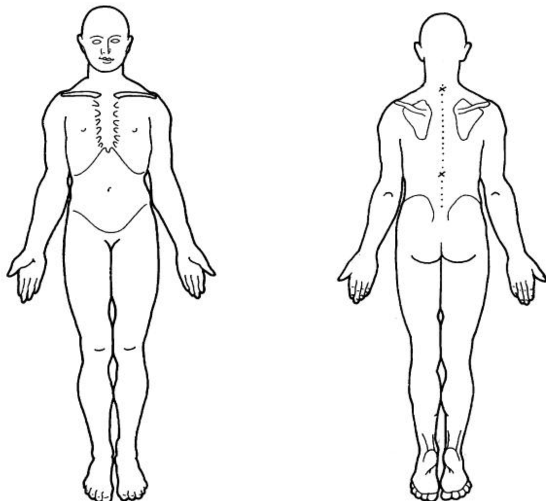
Date:	Procedure:
__________________	____
__________________	____
__________________	____
__________________	____

Diagnostic Tests

	Date:	Significant Results:
X-Ray	_______________	____
EMG	________________	____
MRI/CT	________________	____
Bone Density	_______________	____
Blood Tests	_______________	____

Current Symptoms

Mark area of current symptoms below



What activities or positions make your symptoms worse?

What do you do to relieve your symptoms?

What are your personal goals for physical therapy?

Patient Signature__________________________________

PT Initials____________ Date_________________

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