Medical Screening Intake Questionnaire

Patient's Name		Chief Complaints or Concern	
Date of Birth		Date of Injury or Symptoms	
Reason for Therapy		Date of Last Doctor Visit	

Please indicate if you have received any of the following for current injury.							
Orthopedic Surgeon	☐Yes ☐No	Physiatrist (Pain Doctor)	☐Yes ☐No	MRI	☐Yes ☐No	Physical Therapy	☐Yes ☐No
Neuro Surgeon	☐Yes ☐No	Chiropractor	☐Yes ☐No	CT-Scan	☐Yes ☐No	Occupational Therapy	☐Yes ☐No
Neurologist	☐Yes ☐No	ER Care	☐Yes ☐No	X-Ray	☐Yes ☐No	Massage Therapy	☐Yes ☐No

Did you have surgery for this injury? If yes, please describe and provide the procedure date(s). If no, please write none.

General/Constitutional		Cardiovascular		Musculoskeletal	
Fatigue	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Muscle Pain/Cramps	☐Yes ☐No
Recent Weight Change	☐Yes ☐No	Chest Pain	☐Yes ☐No	Stiffness	☐Yes ☐No
Night Sweats/Fevers	☐Yes ☐No	Coronary Artery Disease	☐Yes ☐No	Joint Pain or Swelling	☐Yes ☐No
Other:	☐Yes ☐No	Heart Surgery/Pacemaker	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Respiratory		**Neurological**		**Gastrointestinal/Urinary**	
Shortness of Breath	☐Yes ☐No	Frequent Headaches	☐Yes ☐No	Nausea/Vomiting	☐Yes ☐No
Excessive Cough/Sputum	☐Yes ☐No	Seizures/Epilepsy	☐Yes ☐No	Abdominal Pain	☐Yes ☐No
Asthma	☐Yes ☐No	Numbness/Tingling	☐Yes ☐No	Rectal Bleeding	☐Yes ☐No
Bronchitis	☐Yes ☐No	Fainting/Dizziness	☐Yes ☐No	Blood in Urine	☐Yes ☐No
Emphysema	☐Yes ☐No	Weakness	☐Yes ☐No	Kidney Stones	☐Yes ☐No
Other:	☐Yes ☐No	Stroke/TIA	☐Yes ☐No	Other:	☐Yes ☐No
Endocrine		**Hematological/Lymphatic**		**Ophthalmological**	
Excessive Thirst/Urination	☐Yes ☐No	Bruise Easily	☐Yes ☐No	Glasses/Contacts	☐Yes ☐No
Thyroid Disease	☐Yes ☐No	Slow to Heal	☐Yes ☐No	Blurred/Double Vision	☐Yes ☐No
Hormone Problem(s)	☐Yes ☐No	Enlarged Glands	☐Yes ☐No	Eye Disease/Injury	☐Yes ☐No
Diabetes	☐Yes ☐No	Other:	☐Yes ☐No	Glaucoma	☐Yes ☐No
Ear-Nose-Throat		**Other**		**Other**	
Hearing Loss or Ringing	☐Yes ☐No	Are you pregnant?	☐Yes ☐No	HIV/AIDS	☐Yes ☐No
Sinus Problems	☐Yes ☐No	Breast Pain/Discharge	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Difficulty Swallowing	☐Yes ☐No	Menstrual Changes	☐Yes ☐No	Cancer	☐Yes ☐No
Voice Change	☐Yes ☐No	Blood Clot	☐Yes ☐No	Depression	☐Yes ☐No
Face Pain	☐Yes ☐No	Confusion/Memory Loss	☐Yes ☐No	Unexplained Weight Loss	☐Yes ☐No
Ear Ache	☐Yes ☐No	Do you use tobacco?	☐Yes ☐No	Other:	☐Yes ☐No
Allergies					
Food or Drink	☐Yes ☐No	Medical	☐Yes ☐No	Environmental	☐Yes ☐No

Please Check the Following Yes or No Boxes
During the past month have you been feeling down, depressed or hopeless? ☐Yes ☐No
During the past month have you been bothered by having little interest or pleasure in doing things? ☐Yes ☐No
Is this something with which you would like help? ☐Yes ☐No ☐Yes, But Not Today
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐Yes ☐No

Please list any medications you are currently taking.		
1.	2.	3.
4.	5.	6.

Have you ever taken a steroid medication? ☐Yes ☐No
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ☐Yes ☐No

Please list any surgeries or other conditions for which you have been hospitalized.
1.
2.
3.

Using the 0-10 scale, with 0 being "no pain" and 10 being "the worst pain imaginable" please describe:
You current level of pain_____/10
The best your pain has been during the past 24 hours_____/10
The worst your pain has been during the past 24 hours_____/10

Please Sign and Date
_____ _____ Patient and/or Guardian Print name Patient and/or Guardian Signature
_____ Today's Date

For Physical Therapist Use Only					
Height	Weight	Blood Pressure	Heart Rate	Temperature	Respiratory Rate
_____ _____ Patient's Account Code Therapist's Initials					