

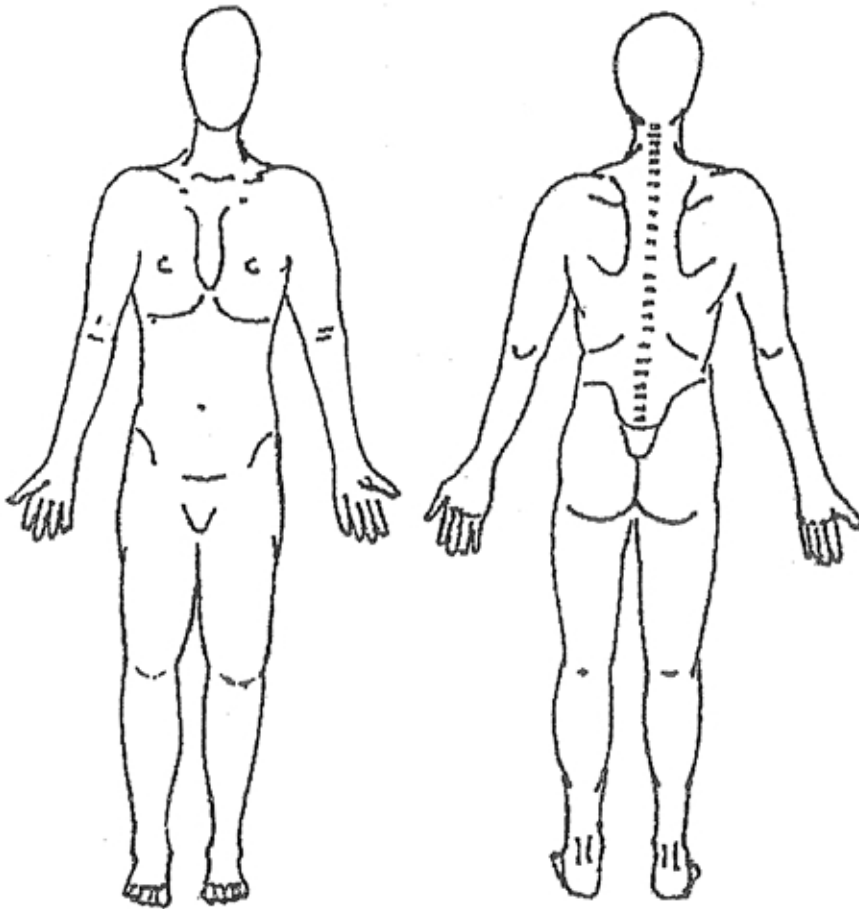
Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yy

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

Key: Pins and Needles = 00000  
Burning = XXXXX

Stabbing = /////  
Deep Ache = ZZZZZ



Please rate your current level of pain on the following scale (check one):

0     1     2     3     4     5     6     7     8     9     10  
(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0     1     2     3     4     5     6     7     8     9     10  
(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

0     1     2     3     4     5     6     7     8     9     10  
(no pain) (worst imaginable pain)

OVER →

# MEDICAL HISTORY SCREENING FORM

## PHYSICAL THERAPY

Circle YES or NO...

**Have you or any immediate family members ever been told you have:**

	<u>Self</u>			<u>Family</u>	
Cancer?	Yes	No		Yes....No	
Diabetes?	Yes	No		Yes....No	
High blood pressure?	Yes	No		Yes....No	
Heart problems?	Yes	No		Yes....No	
Angina/chest pain?	Yes	No		Yes....No	
Stroke?	Yes	No		Yes....No	
Osteoporosis?	Yes	No		Yes....No	
Osteoarthritis?	Yes	No		Yes....No	
Rheumatoid arthritis?	Yes	No		Yes....No	
Pacemaker?	Yes	No			
Are you <b>Pregnant</b> ?	Yes	No			

**In the past 3 months have you had or do you experience?**

A change in your health?.....	Yes....No
Nausea/Vomiting?.....	Yes....No
Fever/chills/sweating?.....	Yes....No
Unexplained weight change?.....	Yes....No
Numbness or tingling?.....	Yes....No
Changes in appetite?.....	Yes....No
Difficulty swallowing?.....	Yes....No
Changes in bowel or bladder function?.....	Yes....No
Shortness of breath?.....	Yes....No
Dizziness?.....	Yes....No
Upper respiratory infection?.....	Yes....No
Urinary tract infection?.....	Yes....No

**Do you have a history of:**

Allergies/Asthma?.....	Yes....No
Headaches?.....	Yes....No
Bronchitis?.....	Yes....No
Kidney disease?.....	Yes....No
Rheumatic fever?.....	Yes....No
Ulcers?.....	Yes....No
Sexually transmitted disease?.....	Yes....No
Seizures?.....	Yes....No
Sensitivity to heat/cold?.....	Yes....No

**Patient Information:**