In Balance Physical Therapy

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Medical Screen

In order to ensure a thorough evaluation, please fill in this form completely. If you do not understand a question, please ask the therapist for assistance. Thank you.

Name: Last/First MI_____

Occupation:_____

Types of physical activity you perform:_____

_____

Please describe your current condition/ injury:_____

_____

_____

_____

Please describe any injuries for which you have been treated, including dates (fractures, dislocations, sprains, hospitalizations, etc.):

_____

_____

_____

_____

_____

What do you wish to accomplish with therapy? What would you like to be able to do when you are done with therapy?_____

_____

_____

_____

Functional Status:

I can sit for _____ minutes easily. I can walk for _____ minutes easily.

I can easily stand for _____minutes. Any problems with driving _____

Have you seen any of the following in the last three months? ___Medical Doctor ___Osteopath

___Physical Therapist ___Dentist___Chiropractor ___Psychiatrist/Psychologist

Form Continued on Reverse

Have you or your family ever been diagnosed as having any of the following conditions?

Self	Family Member		Self	Family Member	
_____	_____	Asthma	_____	_____	Emphysema/Bronchitis
_____	_____	Thyroid Problems	_____	_____	Chemical Dependency
_____	_____	Multiple Sclerosis	_____	_____	Diabetes
_____	_____	Rheumatoid Arthritis	_____	_____	Arthritic Conditions
_____	_____	Depression	_____	_____	Hepatitis
_____	_____	Tuberculosis	_____	_____	Stroke
_____	_____	Kidney Disease	_____	_____	Anemia
_____	_____	Epilepsy	_____	_____	Cancer
_____	_____	Hypertension			
_____	_____	Other: List _____			

Are you currently pregnant?_____

Which of the following over-the-counter medications have you taken in the last week?

____Aspirin ____ Advil/Motrin/Ibuprofen/Aleve ____Tylenol Supplements ____Antacids
_____Laxatives _____Vitamin/Mineral _____ Antihistamines _____Decongestant
_____Other (Please List)_____
_____

Please list any prescription medications you are currently taking (pills, patches, injections):

_____

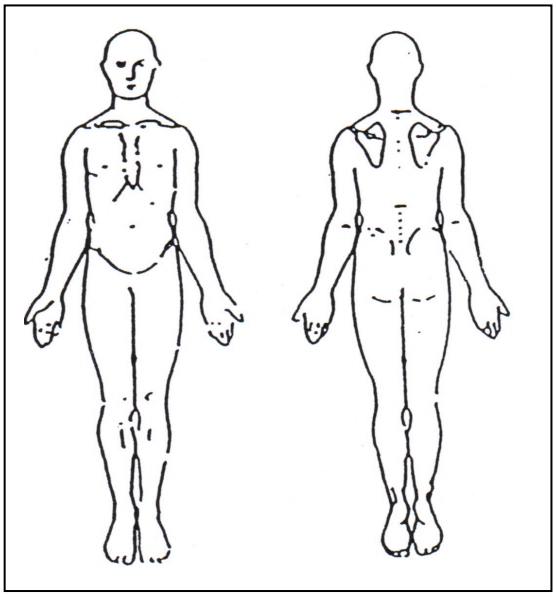
_____

Have you recently noticed any of the following?

_____ Weight Loss/Gain _____ Nausea or Vomiting _____ Weakness _____ Fatigue
_____ Fever, Chills or Sweats _____ Problems Sleeping _____ Numbness or Tingling
_____ Bowel or Bladder Problems

Do you smoke? Yes _____ No _____ If so, how many pack(s) a week? _____
How much alcohol do you consume each week?
_____

Please indicate on the diagram any areas of pain or discomfort:



_____

Patient Signature **Date**

_____

Therapist Signature **Date**

Form reviewed with patient?_____