WEST BILLINGS PHYSICAL THERAPY & SPORTS MEDICINE

Physical Therapy Medical Screening Questionnaire

3307 Grand Ave, Ste 203
Billings, Mt 59102

www.westbillingspt.com

Date: _____

Name: _____

Date of Birth: _____ Age: _____

Gender: M F Smoker: Y N

Pregnant: Y N Trimester: 1st 2nd 3rd

Occupation:

Work related or MVA: Y N

Describe your regular exercise routine:

Past Surgical History (list all & date):

_____

_____

_____

Please List All Current Medications:

_____

_____

_____

Have you had an x-ray, MRI, or other imaging study? Y N

Past Medical History (PMH): Have you been told you have (or had):

Cancer	Y N	Pace Maker	Y N	Lung Disease	Y N
Diabetes I or II	Y N	Deep Vein Thrombosis	Y N	Allergies/Asthma	Y N
Kidney Disease	Y N	Used Corticosteroids?	Y N	Seizures	Y N
Liver Disease	Y N	Osteoporosis	Y N	Ulcers	Y N
Stroke	Y N	Osteoarthritis	Y N	Endometriosis	Y N
High Blood Pressure	Y N	Rheumatoid Arthritis	Y N	Sexually Transmitted Disease	Y N
Heart Disease	Y N	Fibromyalgia	Y N	Recent Illness/Infection	Y N
Angina/Chest Pain	Y N	Migraines or Headaches	Y N	Any other pertinent PMH?	Y N
				Explain:	

Are you currently experiencing:

Change in Health	Y N	Headaches	Y N
Unexplained Weight Loss	Y N	Poor Balance/Falls	Y N
Increased Pain at Night or Rest	Y N	Dizziness	Y N
Fevers/Chills/Night Sweats	Y N	Vision Changes	Y N
Nausea/Vomiting	Y N	Pain/Changes with Menstruation	Y N
Changes with Bowel/Bladder	Y N	Numbness or Tingling	Y N
Pain with Eating	Y N	Shortness of Breath	Y N
Difficulty Swallowing	Y N	Depression	Y N
Changes in Appetite	Y N	Loss of Sensation Anus/Genitals	Y N

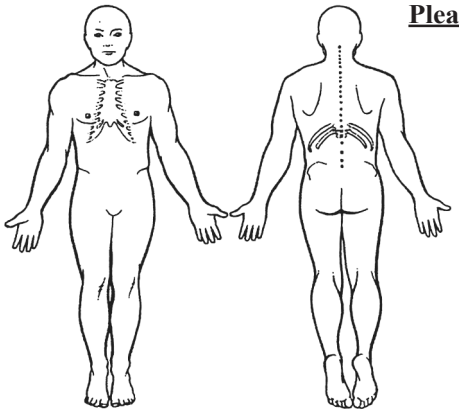
In the past month, have you often been bothered by feeling down, depressed, or hopeless? **Y N**
In the past month, have you often been bothered by little interest or pleasure in doing things? **Y N**
Is this something with which you would like help? Yes, Today / Yes, but not today / No help (circle one)

Are you currently working? **Y N Retired**
Has your pain required you to alter your work? **Y N**

(continued on other side)

Current Symptoms:

Where are you currently having symptoms?_____
What date (approximately) did your present pain begin? _____
How (gradually, suddenly, injury)? _____
My symptoms are currently: **Getting better / Staying about the same / Getting Worse**
Have you received treatment for this problem? **Y N** _____
Have you ever had this problem before? **Y N** _____
If so, how was the problem treated? _____
How long did it take for you to feel better? _____
How are you able to sleep at night? **Fine / Moderate Difficulty / Only with Medication**
What are your goals for therapy? _____
Do you have any barriers to learning? If so, list _____
Do you have any allergies? _____



Please mark areas on the body where you feel pain

Please circle the number that best represents the severity of your pain

Average, for the past 48 hours
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Best, for the past 48 hours
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst, for the past 48 hours
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Does coughing, sneezing, or taking a deep breath make your pain feel worse? **Y N**
Do activities such as bending, sitting, lifting, twisting and/or turning in bed make your pain worse? **Y N**
Do you have pain with bowel, bladder, or sexually related activities/functions? **Y N**

Are you taking blood thinners? **Y N** If yes, is your INR stable? **Y N** What is your INR? _____
Do you have any known diseases or infections that can be transmitted through bodily fluids? **Y N**
Have you had surgery within the past 12 weeks? **Y N** If so, what surgery? _____
Do you have any metal or other implanted devices? If yes, please list _____

What activities make your symptoms worse? _____
What activities make your symptoms better? _____
When do your symptoms feel the best? **AM / PM / Daytime** (Circle One)
When do your symptoms feel the worst? **AM / PM / Daytime** (Circle One)

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1) _____ Rating:_____
2) _____ Rating:_____
3) _____ Rating:_____

Rate your ability: (see scale below)

Unable to perform activity	0 1 2 3 4 5 6 7 8 9 10	**Able to perform activity at same level as before your injury or problem**