



7941 New Chipping Lane, New Kent, VA 23124  
Phone: 757-969-5200 Fax: 757-969-5201

**MEDICAL SCREENING FORM – MOVEMENT, BALANCE, & GAIT**

Date of diagnosis or symptom onset: \_\_\_\_\_

Have you had physical therapy for this before? \_\_\_\_\_

Current prescription medications: \_\_\_\_\_

Current over-the-counter medications/supplements: \_\_\_\_\_

Do you experience any dizziness, lightheadedness, or cloudy vision?      Yes      No

Please circle any of the following activities that are difficult, require caution, or that you are unable to perform:

- |                       |   |
|-----------------------|---|
| Bathing               | Remaining Standing for a Period of Time |
| Dressing              | Squatting                               |
| Sleep                 | Bending Forward                         |
| Household Chores      | Walking on Even Surfaces                |
| Driving               | Walking on Uneven Surfaces              |
| Getting In/Out of Car | Going Up & Down Stairs                  |
| Sit to Standing       | Fine Motor Skills / Hand Use            |

Please circle any of the following which are pertinent to your medical history:

- |                      |                             |
|----------------------|-----------------------------|
| Allergies            | Hernia                      |
| Asthma               | High Blood Pressure         |
| Arthritis            | Kidney Disease              |
| Bronchitis           | Kidney Stones               |
| Cancer               | Metal/Other Implant         |
| Circulatory Disease  | Multiple Sclerosis          |
| Depression           | Night Pain                  |
| Diabetes             | Osteoporosis                |
| Dizziness            | Parkinson’s Disease         |
| Epilepsy             | Prostate Problems           |
| Fainting             | Shortness of Breath         |
| Fever/Chills/Sweat   | Stroke                      |
| Fractures            | Thyroid Problems            |
| Headaches            | Tuberculosis                |
| Heart Attack/Disease | Weight Change               |
| Hepatitis            | Bowel / Urinary Dysfunction |

Please list all surgeries: \_\_\_\_\_

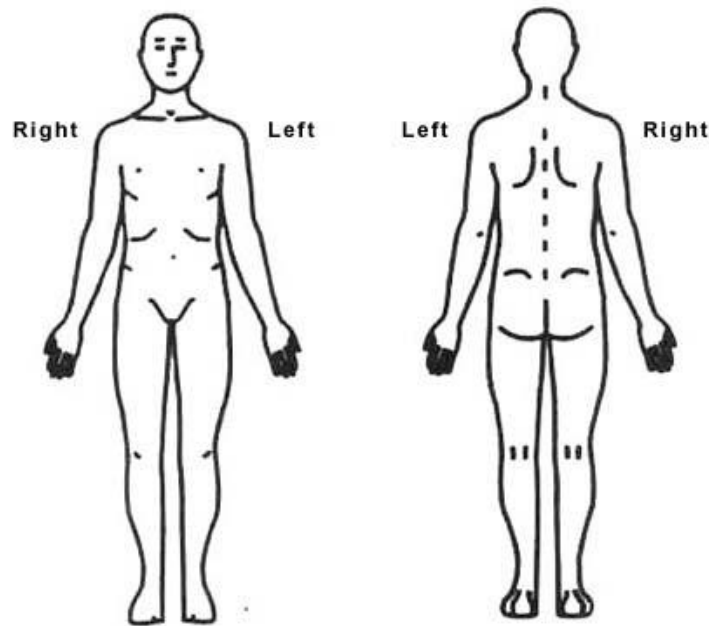
Do you smoke cigarettes? NO YES \_\_\_\_\_ packs per day x \_\_\_\_\_ years

Do you drink alcoholic beverages? NO YES \_\_\_\_\_ drinks per week

How would you describe your general health? \_\_\_\_ Excellent \_\_\_\_ Good \_\_\_\_ Fair \_\_\_\_ Poor

Occupation: \_\_\_\_\_

Typical Leisure/Fitness Activities: \_\_\_\_\_



Please indicate your pain on the body image above using the following key:

// Stabbing XX Burning OO Pins/Needles == Numbness ++ Aching

What are your goals and what do you hope to achieve from your treatment here at APEX Physical Therapy?  
(e.g. return to work, increase walking distance, return to sports/hobbies, increase sitting or standing times...)

\_\_\_\_\_  
\_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_