APEX PHYSICAL THERAPY AND MOVEMENT CENTER

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MEDICAL SCREENING FORM

What injury or problem are we seeing you for today? _____

Date of injury or symptom onset: _____

Is this a: Work Related Injury ____ Sports Related Injury ____ Motor Vehicle Accident ____

For your current condition, have you had any imaging or testing, i.e., X-rays, CT Scan, MRI (please provide approx. dates): _____

Please rate your pain on a scale from 0 (no pain) to 10 (worst pain imaginable) for each below,
At Best _____ At Worst _____ On Average _____ Currently _____

Please choose all that apply; Is your pain…
Constant _____ Getting Better _____ Getting Worse _____ Staying the Same _____

Current prescription medications: _____

Current over-the-counter medications/supplements: _____

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

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

Are you fully vaccinated against COVID-19 (two weeks beyond last required dose)? YES NO

Please list all surgeries: _____

_____

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

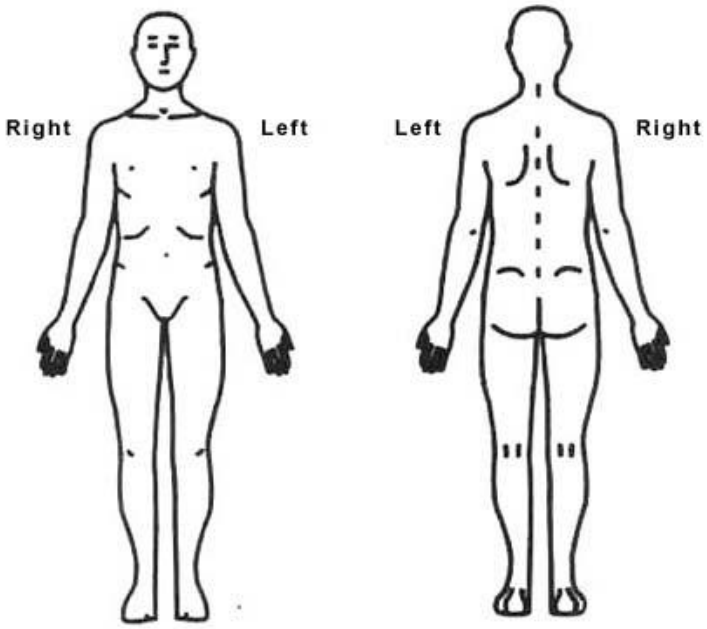
Do you drink alcoholic beverages? NO YES _____ drinks per week

Do you drink caffeinated 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: _____