APEX PHYSICAL THERAPY AND MOVEMENT CENTER

5485 Mooretown Road, Suite E, Williamsburg, VA 23188
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
Dressing
Sleep
Household Chores
Driving
Getting In/Out of Car
Sit to Standing
Remaining Standing for a Period of Time
Squatting
Bending Forward
Walking on Even Surfaces
Walking on Uneven Surfaces
Going Up & Down Stairs
Fine Motor Skills / Hand Use

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
Parkinson's Disease
Prostate Problems
Shortness of Breath
Stroke
Thyroid Problems
Tuberculosis
Weight Change
Bowel / Urinary Dysfunction

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

Please list all surgeries: _____

_____

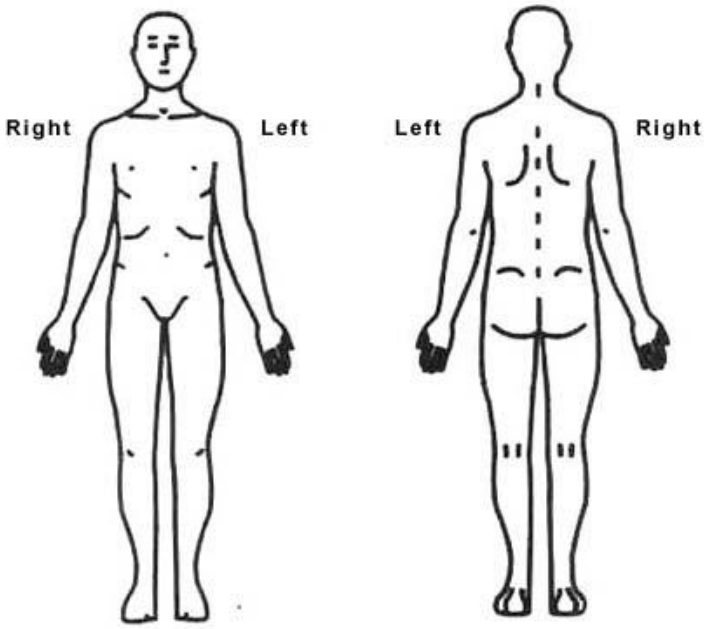
Do you smoke cigarettes? NO YES _____ packs per day x _____ years

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

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: _____