

in Touch

Physical Therapy Physical Therapy Screening Questionnaire

To ensure that you receive a thorough evaluation, please provide us with this important background information about your medical history.

Name _____ Date of Birth _____ Age _____

Date of onset or injury _____ How this injury occurred _____

Please describe your current complaint _____

What makes your symptoms BETTER? Please circle

Heat Standing Resting Medication
Ice Sitting Walking Position change
Other _____

What makes your symptoms WORSE? Please circle

Bending Driving Lifting Walking Sitting Sports
Standing Steps Stairs Working Overhead reaching
Other _____

Have you sought previous treatment for this injury?

Please list any Tests / Findings

X-Ray / MRI / CT Scan _____

Are you currently working? Y N With restriction? Y N

If no, when was the last day of work? _____

Occupation: _____

Have you had any of the following in the past 2 weeks?

Sleep disturbance	Night sweats	Night pain
Weakness	Numbness	Dizziness
Tingling	Fatigue	Headaches
Swelling	Vomiting	Abdominal pain
Nausea	Fever	Chills
Changes in bowel or bladder habits		
Unexplained weight loss / gain		

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

Y N	Currently Pregnant? Due date: _____	Y N	Osteoporosis
Y N	Diabetes	Y N	Stroke
Y N	Heart Problems	Y N	Smoking Habit
Y N	Cancer: Type _____ Date _____	Y N	Fibromyalgia

List **ANY SURGERIES/INJURIES/MEDICAL CONDITIONS** that would be important or helpful for us to know

Date: _____ **Injury/Surgery/Medical Conditions:** _____ **Reason:** _____

Which of the following **Over-the-Counter** and **Prescription** medications have you taken in the past **2 weeks**? Please list how many.

_____ **Prescription Medications** _____

_____ **Over-The-Counter Medications** _____

Do you have any product allergies? ie. Latex etc. *please list* _____

How would you rate your general health? Poor / Fair / Good / Excellent

Patient Signature _____ **Date** _____

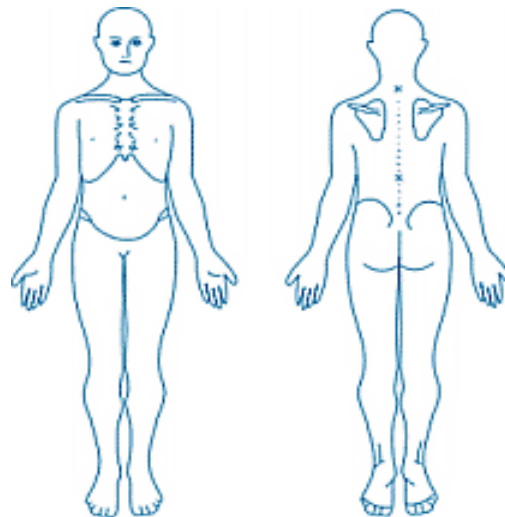
Please indicate your pain on a scale of 0-10, with 0 being no pain, and 10 being the worst pain imaginable (please circle)

0 1 2 3 4 5 6 7 8 9 10

Which of the following symptoms are you experiencing?

Please circle and label on the diagram:

Dull Shooting Sharp Constant
Ache Tingling Burning Numb
Other _____



in Touch

Physical Therapy

Patient _____

Intake reviewed with patient: Y N

Subjective: _____

Physical Therapy Evaluation: Objective

	AROM		PROM	
	R	L	R	L

	R	L		R	L
Neck Ext (C1-2)			Hip Flex (L1-2)		
Neck SB (C3)			Hip Ext (S1)		
Scap Elevation (C4)			Hip IR (L2-4)		
Shoulder Flex (C4-5)			Hip ER (L5-S1)		
Shoulder Abd (C5)			Hip Add (L2-4)		
Shoulder			Hip Abd (L4-S1)		
IR (C5-6)			Knee Ext (L3)		
ER (C5-6)			Knee Flex (S2)		
Biceps (C5-6)			PF (S1)		
Triceps (C7-T1)			DF (L4)		
Wrist Ext (C6)			Everson (S1)		
Wrist Flex (C7)			Inversion (L5-S1)		
Thumb Ext (T1)			Toe Ext (L5)		
Intrinsic Hand (T1)			Other		

Reflexes

Biceps (C5)		Patellar Tendon (L3-4)	
L	R	L	R
Brachioradialis (C6)		Hamstrings (L5)	
L	R	L	R
Triceps (C7)		Achilles (S1)	
L	R	L	R

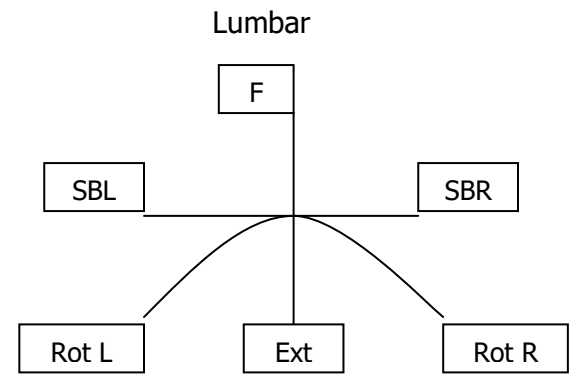
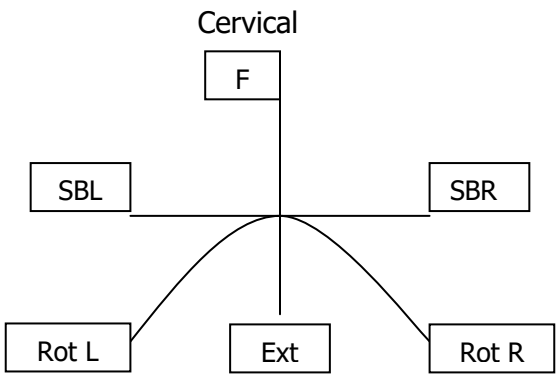
Sensation _____

Circumference _____

Observation / Posture/ MM Length/Flexibility _____

Palpation _____

Special Tests / Other _____



Therapist
Signature _____

Date _____