AGM Physical Therapy

Medical Screening Form

Name: _____ Date:_____

Please circle: YES or NO

Do you have a history of:	Self		Family	
Diabetes?	Yes	No	Yes	No
High Blood Pressure?	Yes	No	Yes	No
Heart Attack?	Yes	No	Yes	No
Heart Disease?	Yes	No	Yes	No
High Blood Cholesterol?	Yes	No	Yes	No
Smoking?	Yes	No	Yes	No
Chest Pain?	Yes	No		
Dizziness/Fainting?	Yes	No		
Shortness of Breath?	Yes	No		
Ankle swelling?	Yes	No		
Night Coughing?	Yes	No		
Stroke?	Yes	No	Yes	No
Cancer?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid Arthritis?	Yes	No	Yes	No
Alcohol use	Yes	No		
Current number of drinks per week? _____				
Allergies?	Yes	No		
Type_____				
Asthma?	Yes	No		
Always have an inhaler with you?	Yes	No		
Childhood diseases?	Yes	No		
Falling?	Yes	No		
Number of times in last year: _____				
Headaches?	Yes	No		
Kidney Disease?	Yes	No		
Lung Disease?	Yes	No		
STDs?	Yes	No		
Seizures?	Yes	No		
Pacemaker/Defibrillator?	Yes	No		
Assistive device (example: cane)?	Yes	No		

In the past 3 months, have you experienced?		
Unexplained change in **your** health?	Yes	No
Explained illness or injury?	Yes	No
Unexplained weight change?	Yes	No
Night Sweats?	Yes	No
Numbness or tingling?	Yes	No
Changes in Bowel/Bladder?	Yes	No
Are you or could you be pregnant?	Yes	No

In the past month, have you frequently been bothered by feeling down, depressed or hopeless? ..... Yes No

In the past month, have you frequently been bothered by having little interest in things or have you lost pleasure in doing things? ..... Yes No

Are the above 2 questions something you would like help with? ..... Yes …. Yes (*but not today*) …. No

Are you afraid physical activity will cause an increase in your pain? ..... Yes No

Are you afraid moving will be harmful to you? ..... Yes No

Do you have a problem with? … (check all that apply)

- Hearing
- Vision

Do you regularly exercise? ..... Yes No

Number of days per week?_____

Number of minutes per session?_____

What is your body weight? _____ **Height?** _____

Please list or provide a copy of the medications that you are currently taking: (Dosages are not necessary)

_____

_____

_____

_____

Please list or provide any medicine allergies that you may have:

_____

_____

Please list any major surgeries in your past:

_____

_____

_____

_____

Other:

_____

_____

_____

Patient/Representative Signature: _____