ETHOS PHYSICAL THERAPY

Physical therapy for your life

Physical Therapy Medical Screening Questionnaire

Name_____ Date of Birth_____ Today's Date_____

Gender: M F (circle one) Occupation_____ Age_____

Past Medical History

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

Are you currently pregnant? □ Yes □ No

Please check all conditions that you have, or have had in the past:

Musculoskeletal:

□ Osteoarthritis □ Rheumatoid Arthritis □ Osteoporosis

□ Bulging Disc □ Fracture (broken bones) □ Headaches/Migraines

□ Gout □ Falls □ Use of cane or walker

Circulation/Respiratory:

□ Heart Attack □ Angina/Chest Pain □ Heart Arrhythmia

□ Pacemaker □ High Blood Pressure □ High Cholesterol

□ Blood Clots/Phlebitis □ Anemia □ Asthma/Shortness of Breath

□ Emphysema □ Chronic Bronchitis □ COPD

Neurological:

□ Stroke/TIA □ Parkinson Disease □ Multiple Sclerosis

□ Epilepsy/Seizures □ Concussion □ Traumatic Brain Injury (TBI)

Endocrine/Digestion:

□ Diabetes □ Kidney Problems □ Liver Problems

□ Bladder Problems/Incontinence □ Thyroid Problems □ GERD/Reflux

□ Ulcers/Stomach Problems □ Low Blood Sugar/Hypoglycemia □ Allergies_____

Other:

□ Tuberculosis □ Hepatitis □ HIV/AIDS

□ Blood Disease □ Psoriasis □ Eczema

□ Skin Disease □ Depression/Anxiety Disorder □ Vertigo

□ Swallowing Problems □ Hearing Problems □ Vision Problems

□ Chronic/Repeated Infections □ Developmental/Growth Problems □ Cancer:_____

Please list all prescription and non-prescription medications, vitamins, home remedies, herbs, etc

If you already have a list please show it to your therapist.

Medication Name:	Dosage	Frequency (times per day)

Please list all surgeries and approximate dates:

_____ _____

_____ _____

CURRENT SYMPTOMS

1. Briefly describe your condition. (Why are you here today?)

   _____

   _____

2. When did this condition begin?_____
3. How did this condition happen (gradually, suddenly, injury)?_____
4. My symptoms are currently: Getting Better / About the same / Getting Worse
5. Have you received any treatment for this problem?
   Check all that apply:

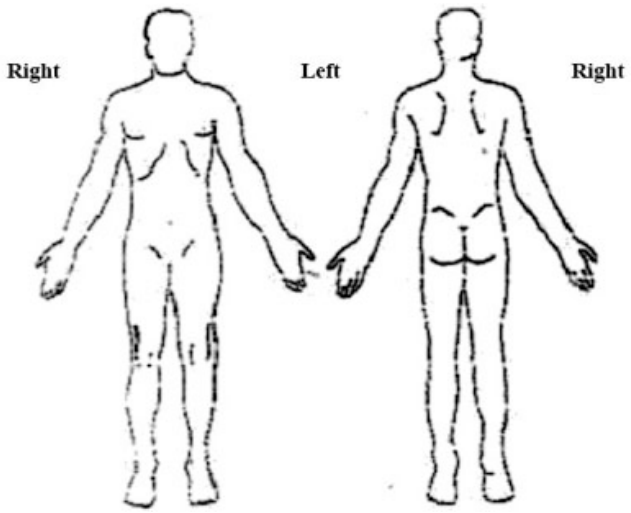
   _____ Surgery _____ MRI _____ Chiropractic care _____ CT scan

   _____ Medications _____ Physical therapy _____ EMG/NCV _____ X-Rays

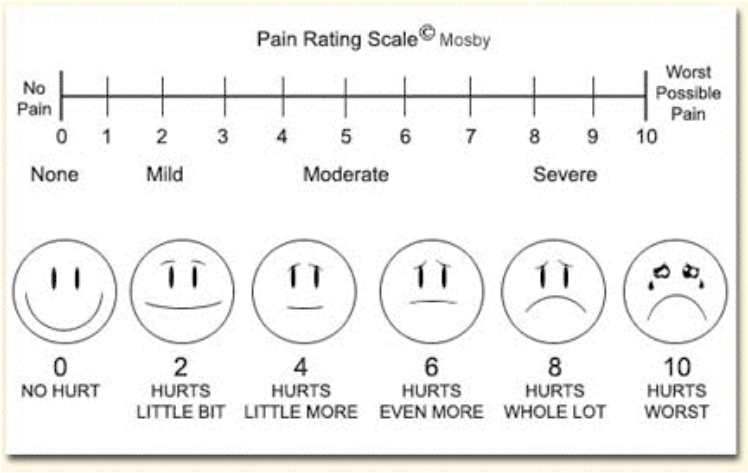
   _____ Injections _____Other:_____
6. Have you had physical therapy for this or any other condition in the past year? If so, please list approximate dates and cause for services. _____

   _____

Please mark the area(s) where you have pain:



How would you rate your pain?
Please circle the following face or number:



Please circle the number below which best represents your overall average level of function.

Cannot do anything	1	2	3	4	5	6	7	8	9	10	**Able to do everything**

What are your goals for therapy? _____

_____

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INFORMED CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist employed by Ethos Physical Therapy, LLC.

Signature of Patient/relative or guardian: _____

Printed Name: _____

Date: _____

Relationship of signor to Patient, if signed by person other than Patient: _____