WEST BILLINGS
Physical Therapy & Sports Medicine
3307 Grand Avenue, STE 203 • Billings, MT 59102-6551

MEDICAL SCREENING QUESTIONNAIRE

DATE: _____

NAME: _____

DATE OF BIRTH: _____ AGE: _____

GENDER: M F SMOKER: Y N

PREGNANT: Y N TRIMESTER: 1ST 2ND 3RD

OCCUPATION: _____

WORK RELATED OR MVA: Y N

DESCRIBE YOUR EXERCISE ROUTINE:

_____

Past Surgical History with Dates

_____

_____

_____

Current Medications

_____

_____

_____

Have you had any Xrays, MRI or other imaging done?
Y N
Where?_____

PAST MEDICAL HISTORY – HAVE YOU BEEN TOLD YOU HAVE OR HAD:

CANCER	Y N	PACE MAKER	Y N	LUNG DISEASE	Y N
DIABETES	Y N	DEEP VEIN THROMBOSIS	Y N	ALLERGIES/ASTHMA	Y N
KIDNEY DISEASE	Y N	USED CORTICOSTEROIDS?	Y N	SEIZURES	Y N
LIVER DISEASE	Y N	OSTEOPOROSIS	Y N	ULCERS	Y N
STROKE	Y N	OSTEOARTHRITIS	Y N	ENDOMETRIOSIS	Y N
HIGH BLOOD PRESSURE	Y N	RHEUMATOID ARTHRITIS	Y N	SEXUALLY TRANSMITTED DISEASES	Y N
HEART DISEASE	Y N	FIBROMYALGIA	Y N	RECENT ILLNESS INFECTION	Y N
ANGINA/CHEST PAIN	Y N	MIGRAINES OR HEADACHES	Y N	ANY OTHER HISTORY? EXPLAIN BELOW*	Y N

*

ARE YOU CURRENTLY EXPERIENCING:

CHANGE IN HEALTH	Y N	HEADACHES	Y N
UNEXPLAINED WEIGHT LOSS	Y N	POOR BALANCE/FALLS	Y N
INCREASED PAIN AT NIGHT OR REST	Y N	DIZZINESS	Y N
FEVERS/CHILLS/NIGHT SWEATS	Y N	VISION CHANGES	Y N
NAUSEA/VOMITING	Y N	PAIN/CHANGES WITH MENSTRUATION	Y N
CHANGES WITH BOWELS OR BLADDER	Y N	NUMBNESS OR TINGLING	Y N
PAIN WITH EATING	Y N	SHORTNESS OF BREATH	Y N
DIFFICULTY SWALLOWING	Y N	DEPRESSION	Y N
CHANGES IN APPETITE	Y N	LOSS OF SENSATION ANUS/GENITALS	Y N

In the past month, have you often been bothered by feeling down, depressed or hopeless? Y N
In the past month, have you often been bothers by little interest or pleasure in doing things? Y N
Is this something with which you would like help? Yes, Today/ Yes, but not today/ No Help (circle one)

Are you currently working? Y N Retired

Has your pain required you to alter your work? Y N

CURRENT SYMPTOMS:

Where are you currently having symptoms? _____

What date (approximately) did your present pain begin? _____

How (gradually, suddenly, injury)?

My symptoms are currently **Getting better / Staying the same / Getting worse**

Have you received treatment for this problem? **Y N Where**_____

Have you ever had this problem before? **Y N**

If so, how was the problem treated? _____

How long did it take for you to feel better?_____

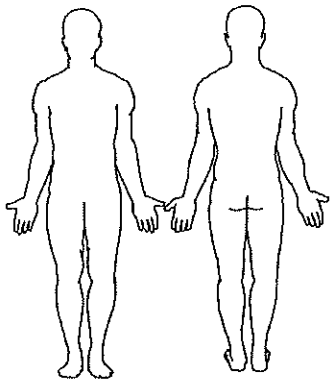
How are you able to sleep at night? **Fine / Moderate difficulty / Only with medication**

What are your goals for therapy? _____

Do you have any barriers to learning? _____

Do you have any allergies? _____

Please circle the number that best represents the severity of your pain



Average in the last 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Best for the past 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Worst for the past 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Does coughing, sneezing or taking a deep breath make your pain feel worse? **Y N**

Do activities such as bending, sitting, lifting, twisting and/or turning in bed make your pain worse? **Y N**

Do you have pain with bowel, bladder or sexually related activities/functions? **Y N**

Are you taking blood thinners? **Y N** If yes, is your INR stable? **Y N** What is your INR? _____

Do you have any known diseases or infections that can be transmitted through bodily fluids? **Y N**

Do you have any metal or other implanted devices? If yes, please list _____

What activities make your pain worse? _____

What activities make your pain better? _____

When do your symptoms feel the best? **AM / PM / Daytime (circle one)**

When do your symptoms feel the worst? **AM / PM / Daytime (circle one)**

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem.

1. _____
2. _____
3. _____