PARDEE
UNC HEALTH CARE

Physical Therapy Medical Screening Form

Date:__________________

Patient Information

Name:
Date of Birth/Age:
Current Problem:
Date of Injury (if applicable):
Recent Surgery:
Date of Surgery:
Currently: ☐working ☐not working ☐retired ☐other
Occupation (or previous occupation):
Sport(s):
School:
Grade:
With whom do you live?
Pets:
Hobbies/Activities:
Beliefs that might affect your care:
Housing: ☐house ☐apartment ☐condo ☐mobile home ☐other:______________________
Do you have stairs? ☐yes ☐no A railing? ☐yes ☐no Steep lot? ☐yes ☐no

History

Latex sensitive ☐yes ☐no
Smoker ☐yes ☐no
Pacemaker ☐yes ☐no
Pregnant ☐yes ☐no
Osteoporosis ☐yes ☐no
Pins or Metal ☐yes ☐no

Please check all the conditions that apply to your immediate **family** (parents, siblings).
☐cancer ☐heart problems ☐diabetes
☐stroke ☐inflammatory arthritis
☐depression ☐kidney disease ☐alcoholism

Have you **Ever** been diagnosed with any of the following conditions?(check all that apply)
☐cancer ☐rheumatoid arthritis
☐diabetes ☐other arthritis
☐high blood pressure ☐depression
☐heart problems ☐tuberculosis
☐stroke ☐bone/joint infection
☐HIV ☐hepatitis
☐asthma ☐COPD
☐chemical dependency ☐seizures
☐blood clots ☐other:____________

Please rate your general health: ☐excellent ☐good ☐fair ☐poor
Any major life changes in the past year? ☐yes ☐no Explain:__________________________
Past surgeries/injuries/hospitalizations:____
Any allergies? ☐yes ☐no Please Explain:____

Recently, I have experienced the following (check all that apply):
☐unexplained weight loss ☐difficulty swallowing ☐dizziness
☐poor balance/falls ☐headaches ☐depression
☐fever/chills/sweats ☐nausea/vomiting ☐shortness of breath
☐numbness/tingling ☐change in appetite ☐change in bowel/bladder
☐other:______________________ ☐change in vision ☐none

Current Medications/Supplements (or provide a list we may copy)

Medication Name	Used For	Dosage	Times per day

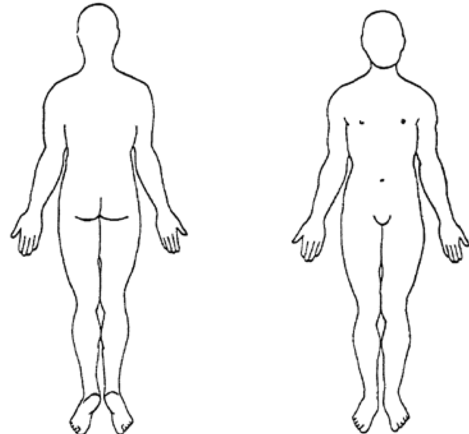
Health Care Management Team
Please list health care practitioners whose care you are currently under (name and title): ______________________________ ______________________________
Date of last physical exam by a medical doctor (MD): ______________

Current Condition
What are your current symptoms?______________________________ When did these problems start?______________________________ How did this happen?______________________________ Have you ever had this problem before? □yes □no Please list any previous treatment for your current condition:______________________________ ______________________________ Have you had any imaging studies done for this problem? (x-rays, MRI, etc.) □yes □no If yes, explain:______________________________ Are you currently: □getting better □getting worse □staying about the same
Using the 0 to 10 scale, with 0 being "*no pain*" and 10 the "*worst pain imaginable*" describe: Your **current** level of pain while completing this survey: 0…1…2…3...4...5...6...7...8...9...10 Circle your **best** pain level during the past 24 hours: 0…1…2…3...4...5...6...7...8...9...10 Circle your **worst** pain level during the past 24 hours: 0…1…2…3...4...5...6...7...8...9...10 **Easing Factors:** Identify up to 3 positions or activities that make you feel better: __________ __________ __________ **Aggravating Factors:** Identify up to 3 positions or activities that make you feel worse: __________ __________ __________ **Functional Activities:** Identify activities important to you that you are experiencing difficulty performing due to your current condition: ______________________________ ______________________________
What are your physical therapy and/or fitness goals?

Body Chart

Please mark the areas where you feel symptoms, using the following symbols to describe your symptoms:

↓ shooting/sharp pain
O dull/ache
× numbness
^ tingling



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Patient Signature:______________________________