

**MT. STUART PHYSICAL THERAPY
P.T. SCREENING FORM**

To ensure you receive a complete and thorough evaluation, please provide us with this important background information. If you do not understand a question, please ask. Thank you for your time.

NAME: _____ DATE OF BIRTH(AGE) _____
PHONE Work/Day _____
EMERGENCY CONTACT (name and number) _____
OCCUPATION _____
LEISURE ACTIVITIES _____

Date and Type of Injury/Surgery _____

Please list the main reason(s) or goals(s) why you are trying Physical Therapy? (in order of importance)

1. _____
2. _____
3. _____

Are you currently or have recently seen any of the following? (please circle and describe the reason)

Dentist _____
Chiropractor _____
Massage Therapy _____
Medical Doctor _____
Occupational Therapy _____
Osteopath _____
Physical Therapist _____
Psychiatrist/Psychologist _____

Have **YOU** ever been diagnosed and/or treated for any of the following conditions?

Please **CIRCLE** and **DESCRIBE**.

Adrenal Insufficiency or Adrenal Fatigue	Heart Problems
Anemia	High Blood Pressure
Arthritis	Hepatitis A, B, C
Asthma	Kidney Disease
Epilepsy/seizure disorder	Narcotics/Alcohol Dependency
Emphysema/Bronchitis	Stroke
Fibromyalgia/Chronic Fatigue Syndrome	Thyroid Problems
OTHER _____	

Is there **FAMILY HISTORY** of any of these diseases, if so, who?

Anemia	Diabetes	Kidney Disease
Arthritis	Epilepsy	Mental Illness
Alcoholism	Headaches	Stroke
Cancer	Heart Disease	Tuberculosis

Please list previous surgeries, injuries, and/or medical conditions, and type of treatment used

DATE(approximate)	INJURY/SURGERY/CONDITION	TREATMENT
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any imaging studies taken (i.e. X-Ray, MRI, CT Scan, etc)? If so, which one and for what reason? _____

Do you ever experience urinary or bowel leakage (including with coughing and/or sneezing) Yes No.

Please list any prescription medications and/or supplements, including dosage, you are currently taking (including pills, injections, skin patches, vitamins, minerals, etc.)

Circle which **OVER THE COUNTER** medications you have taken in the last week?

Aspirin	Tylenol	Laxatives
Advil/Motrin	Decongestants	Antihistamines
Ibuprofen	Antacid	Vitamins/Mineral supplements
Other _____		

How many caffeinated beverages (soda, coffee, tea, etc)do you drink per day? _____

How much tobacco do you use per day? _____

How did you find out about Mt. Stuart Physical Therapy?

Newspaper Doctor Radio Friends Other:_____

Thank you for taking the time to complete this form.

Patient Signature

Date