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.

Please print and complete all entries					
Patient Name (Last, First, MI)		Date of Birth	Age	Marital Status	Today's Date
Mailing address (Street, City, Zip)		Home phone: work:			
		Cell phone:			
		Email address:			
Social Security No.		Who is financially responsible for this bill? DOB			
Employer Name and Phone No.		Occupation			
Name of Emergency contact	Relationship	Phone number			

Height: _____ Weight: _____ Blood Pressure: _____
Occcupation_____
Leisure Activities _____

Doctor who referred you: _____
Date (M/D/YR) and Type of Injury/Surgery_____
How did you injure yourself? _____
Where did you injure yourself (i.e. playing school sports, recreational sports, working in the yard)_____
_____

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?

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	Alcoholism	Headaches	Stroke
Cancer	Heart Disease	Tuberculosis	Arthritis	Epilepsy	Mental Illness

Have you been in physical therapy any place else in this current year? Yes / NO
Location_____ Approximately how many visits_____

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

DATE (approximate) INJURY/SURGERY/CONDITION TREATMENT

_____

_____

_____

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/ Naproxen	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: _____

_____

Patient Signature Date