Cornerstone Physical Therapy & Wellness

Medical Screening Form **Date:**____________

Name: ___________________________________

Referring Doctor:__________________________

Circle Yes or No

Do you or your immediate family member(s) have:

	Self	**Family**
Cancer	yes/no	yes/no
Diabetes	yes/no	yes/no
Heart Problems	yes/no	yes/no
High Blood Pressure	yes/no	yes/no
Angina/chest pain	yes/no	yes/no
Stroke	yes/no	yes/no
Osteoporosis	yes/no	yes/no
Osteoarthritis	yes/no	yes/no
Rheumatoid arthritis	yes/no	yes/no
Head/Neck/Spine Trauma	yes/no	yes/no

In the past 6 months have you had or do you experience:

A major change in your health	yes/no
Nausea/vomiting	yes/no
Fever/chills/sweats/anxiety	yes/no
Unexplained weight loss	yes/no
Numbness or tingling	yes/no
Changes in appetite	yes/no
Difficulty swallowing	yes/no
Changes in bowel/bladder function	yes/no
Dizziness	yes/no
Fainting	yes/no
Double vision	yes/no
Difficulty speaking	yes/no
Shortness of breath	yes/no
Upper respiratory infection	yes/no
Urinary tract infection	yes/no

Do you have a history of?

Allergies/asthma	yes/no
Headaches	yes/no
Bronchitis	yes/no
Kidney disease	yes/no
Rheumatic fever	yes/no
Ulcers	yes/no
Sexually transmitted disease	yes/no
Seizures	yes/no
Thyroid Problems	yes/no
Chemical Dependency	yes/no

Therapist Signature:_________________________

Please List any other conditions, significant injuries, surgeries, or reasons for hospitalization.

____
____
____
____
____

Are you or might you be Pregnant? yes/no

Please List Over-The-Counter Medications you have taken in the last week

____
____
____
____

Please List Prescription Medications you are currently taking (pills, injections, patches)

____
____
____
____
____

Please List any Allergies (i.e. medications, latex, bee sting, seasonal)

____
____

Please (X) any of the following whose care you are under:

___ Medical Doctor ___ Chiropractor
___ Psychiatrist/Psychologist ___ Orthopedist
___ Osteopath ___ Neurologist
___Other:_________________

Patient Signature: ___________________________