LILIAN HOLM WELLNESS
PHYSICAL THERAPY AND WELLNESS COACHING

MEDICAL SCREENING QUESTIONNAIRE

Name:_____**DOB:**_____**Date:**_____
Gender: M F Age:_____ **Occupation:**_____**Pregnant: Y N**

Past Surgical History:_____

Current Medications:_____

Have you had an X-ray, MRI or other tests?_____

C*ircle* any conditions that apply to you, <u>underline</u> if a close relative has been diagnosed with any of the following). Add any additional diagnoses/conditions you may have.

Cancer	Diabetes	Kidney disease	Stroke
High blood pressure	Heart disease	Angina/Chest pain	Ulcers
Osteoporosis	Osteoarthritis	Rheumatoid arthritis	Fibromyalgia
Allergies/Asthma	Lung disease	Liver disease	Sexually transmitted disease

Unexplained weight loss	Fever/chills/sweats	Bowel or bladder function change (incl.leaking)	
Depression	Changes in appetite	Poor balance/falls	Loss of menstrual period
Weakness	Nausea/vomiting	Difficulty swallowing	Shortness of breath
Numbness/tingling	Dizziness	Night pain	Headaches

or pain correlated with eating, fasting, urinating, defecating, sleeping, coughing, breathing, recent travel

Do you take blood thinners? Y N Do you take osteoporosis drugs? Y N
Are you allergic to latex? Y N Have you had a recent illness?_____

CURRENT SYMPTOMS:

Where are you having symptoms?_____

When did your symptoms start?_____
How?(gradually, suddenly, injury):_____

My symptoms are currently(circle): getting better /about the same/getting worse

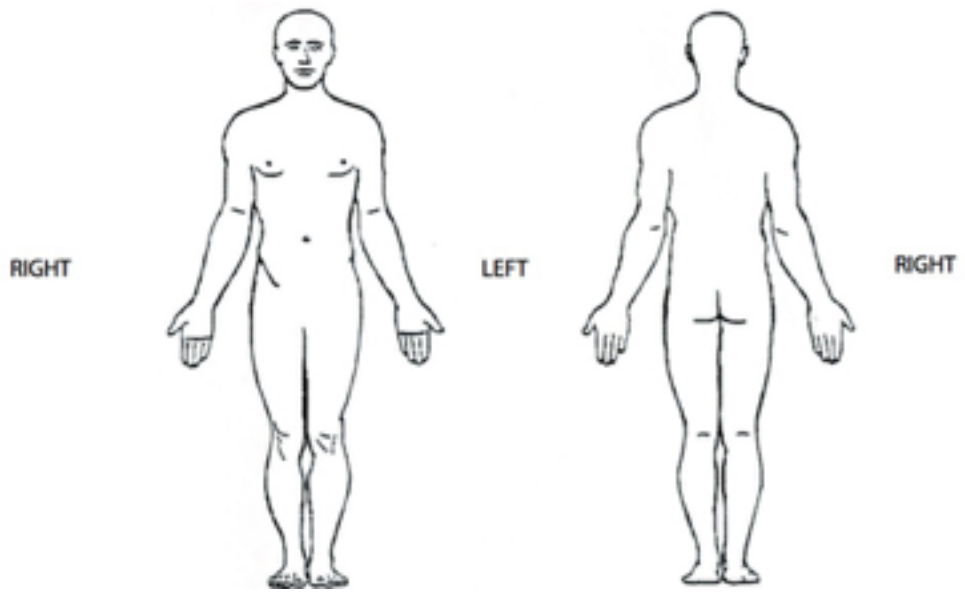
Have you received any treatment for this problem? (please describe type and

outcome):_____

Have you had this problem before? If so, please describe duration and

treatment:_____

Please mark the areas where you feel pain on the figure below. Please circle on the scale below the numbers which best represents the average, lowest and worst severity of your pain over the last 48 hours.



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

Please mark numbness or tingling with N or T in the area where they occur

What makes your symptoms better?_____

What makes your symptoms worse?_____

Best and worst times of day?_____

What is your goal for treatment?_____

List functional activities you are currently unable to perform, or are severely limited, due to your symptoms._____

Do you limit activity or avoid certain positions in order to avoid pain or worsening? Y N

Over the past two weeks, have you felt hopeless or depressed, or the loss of interest or pleasure in doing things? Yes No

If yes, would you like to have help with this? Yes No