Lilian Holm Wellness

Physical therapy and Wellness coaching

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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?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you experiencing any of the following? (*circle* any that apply, underline if a close relative (parents, siblings has been diagnosed with any of the following)**

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):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

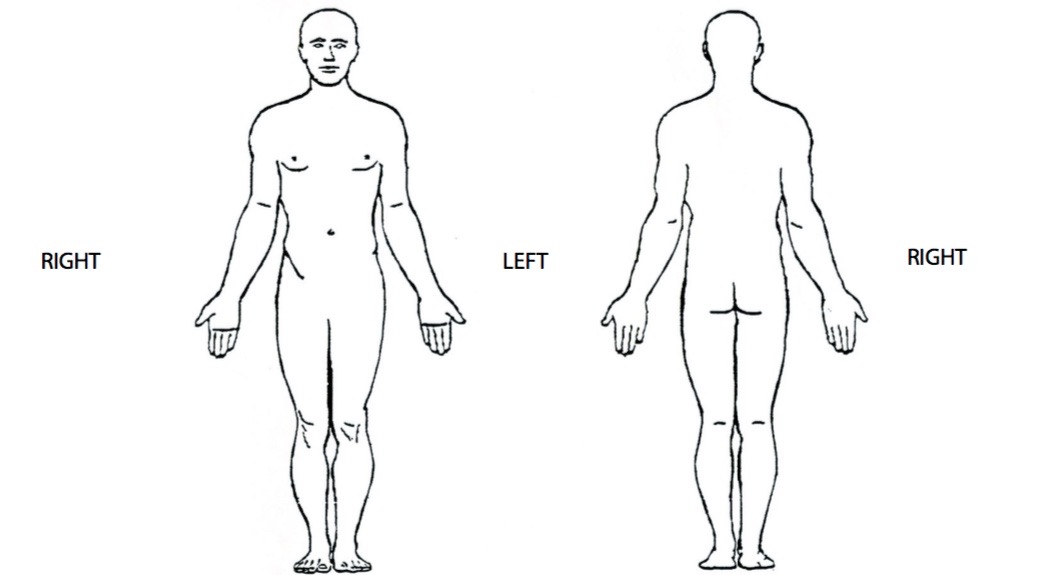
**My symptoms are currently(circle):** getting better /about the same/getting worse

**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