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:_____

Diagnoses:_____

Primary complaint:_____

_____

Current Medications:_____

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

Are you experiencing 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
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
Symptoms when you look down	Painful intercourse	Frequent falls	Dislocations/subluxations

Do you take blood thinners? Y N Do you take osteoporosis drugs? Y N
Allergies:_____ **Have you had a recent illness?**_____

CURRENT SYMPTOMS:

When and how did your symptoms start?_____

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

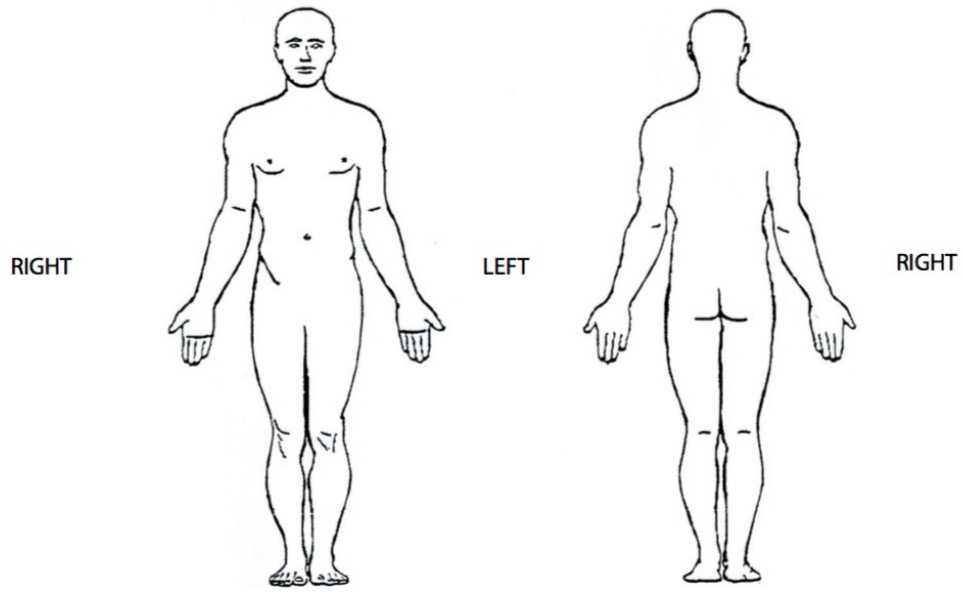
Have you had this problem before? Have you received any treatment for this problem?

_____

_____

Outcome of previous therapy:_____

Please mark the areas where you feel pain on the figure below. Circle on the scale below the numbers which best represent the average, lowest and worst severity of your pain. If several areas, please number, with most severe symptom = 1



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

Beighton score, if known:_____/9 Most unstable joints:_____

What makes your symptoms better?_____

What makes your symptoms worse?_____

Best and worst times of day?_____

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

What is your goal for treatment (other than pain relief)?_____

_____

What would you like to be able to do?_____

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