South Hills Physical Therapy Clinic

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Medical Screen

To ensure a thorough evaluation, please fill in this form completely. If you do not understand a question, ask the therapist for assistance. Thank you.

Name:_____ **Address:**_____

Home Phone:_____ **Work Phone:**_____

Occupation:_____ **E-mail address:** _____

Types of physical activity you perform:_____

_____

Please describe your current condition/ injury:_____

_____

_____

Covid vaccines: _____

What do you wish to accomplish with therapy? What would you like to be able to do when you are done with therapy?_____

_____

_____

Have you seen any of the following in the last three months?

_____Medical Doctor _____Osteopath _____Physical Therapist _____Dentist
_____Chiropractor _____Psychiatrist/Psychologist

Have you or your family ever been diagnosed as having any of the following conditions?

Self	**Family Member**		**Self**	**Family Member**	
_____	_____	Asthma	_____	_____	Emphysema/Bronchitis
_____	_____	Thyroid Problems	_____	_____	Chemical Dependency
_____	_____	Multiple Sclerosis	_____	_____	Diabetes
_____	_____	Rheumatoid Arthritis	_____	_____	Arthritic Conditions
_____	_____	Depression	_____	_____	Hepatitis
_____	_____	Tuberculosis	_____	_____	Stroke
_____	_____	Kidney Disease	_____	_____	Anemia
_____	_____	Epilepsy	_____	_____	Cancer
_____	_____	Other (Please List)_____			

Form Continued on Reverse →

Are you currently pregnant?_____

Please describe any injuries for which you have been treated, including dates (fractures, dislocations, sprains, hospitalizations, etc.):_____

_____

_____

Which of the following over-the-counter medications have you taken in the last week?

_____Aspirin	_____Advil/Motrin/Ibuprofen/Aleve	_____Tylenol
_____Laxatives	_____Vitamin/Mineral Supplements	_____Antacids
_____Antihistamines	_____Decongestants	_____Other (Please List)

Please list any prescription medications you are currently taking (pills, patches, injections):_____

_____

Have you recently noticed any of the following?

_____Weight Loss/Gain	_____Nausea or Vomiting	_____Weakness
_____Fatigue	_____Fever, Chills or Sweats	_____Problems Sleeping
_____Numbness or Tingling	_____Bowel or Bladder Problems	

Do you smoke? Yes ___ No ___ If so, how many pack(s) per week? _____

How much alcohol do you consume each week? _____

_____ _____

Patient Signature **Date**

_____ _____

Therapist Signature **Date**

Form reviewed with patient? _____