Agile PHYSICAL THERAPY

Health Screening Questionnaire

Name: _____ **Age:**_____ **Date:** _____

Leisure activities, including exercise routines: _____

Occupation and daily work activities: _____

Are you latex sensitive? ❑ **Yes** ❑ **No** **Do you smoke?** ❑ **Yes** ❑ **No**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? ❑ **Yes** ❑ **No**

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ muscle weakness
- ❑ nausea/vomiting
- ❑ unexplained weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ changes in bowel or bladder function
- ❑ numbness or tingling
- ❑ fever/chills/sweats
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ vision changes
- ❑ cough
- ❑ falls
- ❑ shortness of breath
- ❑ fainting
- ❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ HIV
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Do you have a pacemaker? ❑ **Yes** ❑ **No**

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ stroke
- ❑ blood clots
- ❑ diabetes
- ❑ thyroid problem
- ❑ heart problems
- ❑ high blood pressure

Please list ANY medications you are currently taking (INCLUDING pills, injections, and/or skin patches). You may attach a list if needed:

1. _____ 2._____ 3._____

Have you ever taken steroid medications for any medical conditions?
❑ **Yes** ❑ **No** **When?**_____
Have you ever taken blood thinning or anticoagulant medications for any medical conditions?

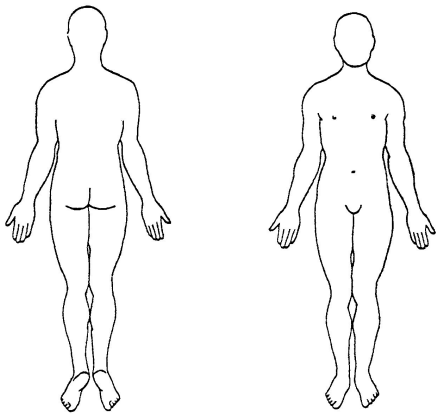
TURN OVER →

❑ **Yes** ❑ **No** **When?**_____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right using the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
/// **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are constant ❑ Are constant, but change with activity

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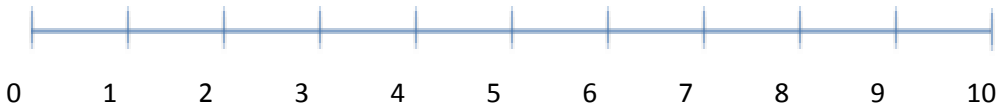

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:_____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

Have you received any treatment for this problem before today (chiropractic care, injections, etc)?

_____

Please list any specific tests performed for this problem (x-ray, MRI, labs, etc):

_____

Have you ever had this problem in the past? ❑ **Yes** ❑ **No** **When:**_____
What treatment have you received in the past? _____

_____

During the past month, have you been feeling down, depressed or hopeless?
❑ **Yes** ❑ **No**
During the past month, have you often been bothered by having little interest or pleasure in doing things?
❑ **Yes** ❑ **No**
Would you like help with this today?
❑ **Yes** ❑ **No**