Name: _____ **Date: _____**

Chart # _____

MIDOUTH ORTHOPAEDIC REHABILITATION
MEDICAL SCREENING FORM

CIRCLE YES or NO…

In the past YEAR have you been seen by:

Medical Doctor	YES	NO
Physical Therapist	YES	NO
Chiropractor	YES	NO
Osteopath	YES	NO
Dentist	YES	NO
Psychiatrist/Psychologist	YES	NO
Other Health Care Professional	YES	NO

Please Specify: _____

Have you EVER been diagnosed with having any of the following conditions?

Cancer	YES	NO
Diabetes (Type 1 or 2)	YES	NO
Stroke	YES	NO
Heart Attack	YES	NO
High Blood Pressure (HTN)	YES	NO
Thyroid Disorders	YES	NO
Seizures	YES	NO
Osteoporosis	YES	NO
Chemical Dependencies	YES	NO
Asthma	YES	NO
Osteoarthritis	YES	NO
Rheumatoid Arthritis	YES	NO
Depression	YES	NO
Other Psychiatric Disorders	YES	NO
Kidney Disorders	YES	NO
Lung Disorder	YES	NO
Emphysema	YES	NO
COPD	YES	NO
GERD (gastric reflux)	YES	NO
Head Injury	YES	NO
Sexually Transmitted Disease	YES	NO
Other	YES	NO

Please Specify: _____

Have you RECENTLY had:

Unexplained Weight Loss	YES	NO
Loss of Appetite	YES	NO
Fever/Chills	YES	NO
Night Sweats	YES	NO

CIRCLE YES or NO…

Disturbed Sleep by Pain	YES	NO
Nausea and/or Vomiting	YES	NO
Dizziness	YES	NO
Loss of Consciousness	YES	NO
Difficulty Swallowing	YES	NO
Difficulty Articulating Words	YES	NO
Visual Problems	YES	NO
Ringing in Ears	YES	NO
Joint Pain/Swelling	YES	NO
Urinary Incontinence	YES	NO
Urinary Retention	YES	NO
Bowel Problems	YES	NO
Numbness and/or Tingling	YES	NO
Coordination Problems	YES	NO
Loss of Balance	YES	NO
Fall(s)	YES	NO
New Onset of Headaches	YES	NO
Hearing Problems	YES	NO
Hoarseness	YES	NO
Cough	YES	NO
Shortness of Breath	YES	NO
Chest Pain	YES	NO
Sexual Dysfunction	YES	NO
OTHER	YES	NO

Please Specify: _____

Have you recently (since onset of this condition) had:

X-Rays	YES	NO
CT Scan	YES	NO
MRI	YES	NO
Bone Scan	YES	NO
Myelogram	YES	NO
EMG	YES	NO
Nerve Conduction Test	YES	NO
Stress Test	YES	NO
Blood Test	YES	NO
OTHER	YES	NO

Please Specify: _____

Name: _____ Date: _____

Chart # _____

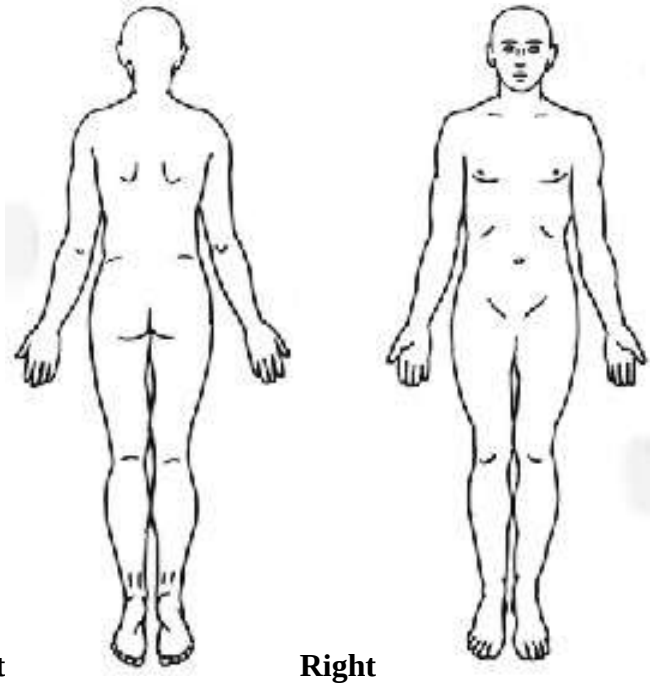
MIDOUTH ORTHOPAEDIC REHABILITATION
MEDICAL SCREENING FORM

Please list current medications (prescription and/or over the counter): _____
_____

Please list previous surgeries/hospitalizations: _____
_____

Please indicate all examinations, tests and treatment you've received for this condition (e.g. doctor visits, imaging, medications, etc- include approximate dates**)**
_____
_____

Please shade the body diagram below to indicate where you feel symptoms during this episode.



Left **Right** **Left**

Please indicate your current level of symptom intensity on the numerical scale below.