Medical Screening Questionnaire

Date: _____
Name: _____
Insurance: _____
Doctor: _____

Gender: M F Age:
Tobacco/Vaping use: Y N Pregnant: Y N
Occupation:_____
Describe your regular exercise routine:_____

_____

Marital Status: _____

Past Surgery (CCCHC patient omit)

_____

_____

_____

Current Medications (CCCHC patient omit)

_____

_____

Have you had an x-ray, MRI, or other imaging study? Y N

Height: _____ **Weight:** _____

Past Medical History: Please circle each condition that you have been told you have (or had).

Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Heart Disease	Angina/Chest Pain	Ulcers	Fibromyalgia
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Sexually Transmitted Disease	
Allergies/Asthma	Lung Disease			

Do you have or have you had a recent illness or infection (explain if yes)? _____
Are you allergic to latex? YES NO Do you take blood thinners? YES NO Other:

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO
During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Currently I am experiencing (circle all that apply):

Fever/chills/sweats	Poor balance (falls)	Anxiety		
Unexplained weight loss	Numbness or Tingling	Changes in appetite	Difficulty swallowing	Depression
Shortness of breath	Dizziness	Headaches	Changes in bowel or bladder function	
Nausea /Vomiting	Increased pain at night			

CURRENT SYMPTOMS

Where are you currently having symptoms? _____
Briefly describe your symptoms/pain: _____
What date (approximately) did your present pain start_____
How did it start? (gradually, suddenly, injury)?_____
My symptoms are currently: **Getting better / About the same / Getting worse / Fluctuating**
Have you received any treatment for this problem? **YES / NO** Have you ever had this problem before: **YES / NO**
If so, how was the problem treated?_____
How long did it take for you to feel better? _____
How are you able to sleep at night? ☐ Fine ☐ Moderate Difficulty ☐ Only with medication
What is your personal goal for therapy? _____

_____

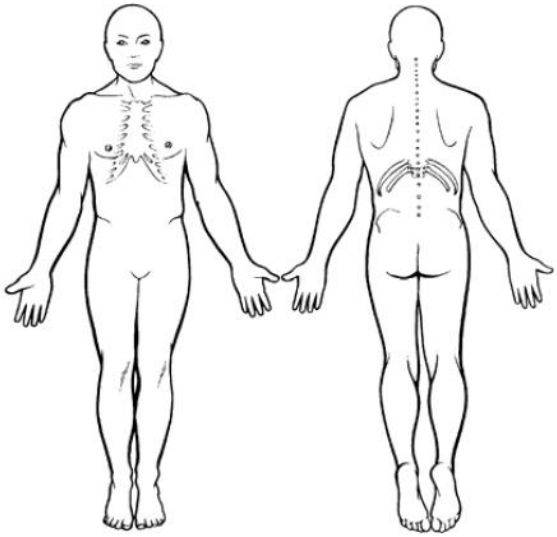
Do you have any barriers to learning, if so list? _____

_____

CONSENT: I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered._____(Sign)

TURN OVER

Body Chart:
Please mark the areas
where you feel pain on



On the scales below, please circle the number which best represents the severity of your pain is.

Average for the last 24 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Average for the last week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Best for the last week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst for the last week

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

How often do you experience your symptoms? (percent of time**)**

1-Constant (76-100%), 2-Frequently (51-75%), 3-Occassionally (26-50%), 4-Intermittently (0-25%)

How much have your symptoms interfered with your daily activity?

1-Not at all, 2-A little bit, 3-Moderately, 4-Quite a bit, 5-Extremely

In general, how would you say your overall health is right now?

1-Excellent, 2-Very good, 3-Good, 4-Fair, 5-Poor

Please circle the number below which best represents your overall average level of function.

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 **Able to do everything**

What makes your symptoms better? _____

_____

Please circle the activities which make your pain worse:

Sitting Standing Laying down Walking Stress

Please list the best and worst time of day for your symptoms } Best-
Worst-

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1) _____

2) _____

3) _____