Kansas City Orthopaedic Institute
Physical Therapy
Medical Screening Form

Name:_____ Age: _____ DOB: ____/____/____ Today's Date: ____/____/____
Occupation: _____ email address: _____
Dr. who referred you to our office: _____ Is this injury job related? Yes / No
Date of last physical exam: _____ Primary care physician: _____
Reason for today's visit: left / right knee / shoulder Date of injury or first symptoms: _____
Details of current injury or symptoms: _____
_____

Circle YES or NO…

Have you or any immediate family member ever been told you have?:	**Self**	**Family**
Cancer	Yes…No	Yes….No
Diabetes	Yes…No	Yes….No
High blood pressure	Yes…No	Yes….No
Heart disease	Yes…No	Yes….No
Angina/chest pain	Yes…No	Yes….No
Stroke	Yes…No	Yes….No
Osteoporosis	Yes…No	Yes….No
Osteoarthritis	Yes…No	Yes….No
Rheumatoid arthritis	Yes…No	Yes….No
Obstructive Pulmonary Disease	Yes…No	Yes….No
Kidney Disease	Yes…No	Yes….No
Thyroid Disease	Yes…No	Yes….No
AIDS/HIV	Yes…No	Yes….No
Hepatitis	Yes…No	Yes….No

In the past 3 months have you had or experienced?:

A change in <u>your</u> health	Yes	No
Nausea/Vomiting	Yes	No
Fever/chills/sweats	Yes	No
Unexplained weight change	Yes	No
Numbness or tingling	Yes	No
Changes in appetite		
Difficulty swallowing	Yes	No
Changes in bowel or bladder function	Yes	No
Shortness of breath	Yes	No
Dizziness	Yes	No
Upper respiratory infection	Yes	No
Urinary tract infection	Yes	No

Have you consulted an attorney for your current problem?……Yes….No

Current Medications / dosage: None: _____
_____
_____
_____
_____
_____
_____

Drug Allergies: ☐No known allergies
_____
_____

Are your symptoms: (check one)
Getting worse Staying the same Improving

Are you currently:
Pregnant Depressed Under Stress

How are you able to sleep at night? (check one)
☐ Fine ☐ Moderate difficulty ☐ Only with medication

Do you have a problem with:
☐ Hearing ☐ Vision ☐ Speech ☐ Communication

What is your preferred learning method:
☐ Verbal ☐ Written ☐ Demonstration

Do you use:
☐ Tobacco If yes, then _____packs x _____ years.
Last tobacco use _____
☐ Alcohol If yes, how many drinks do you routinely have per week? _____/week.

Have you ever had a problem with addiction? Yes / No

Past Surgical History/treating physician / dates:
_____
_____
_____

Review of symptoms: please check the box if you have or have had in the past

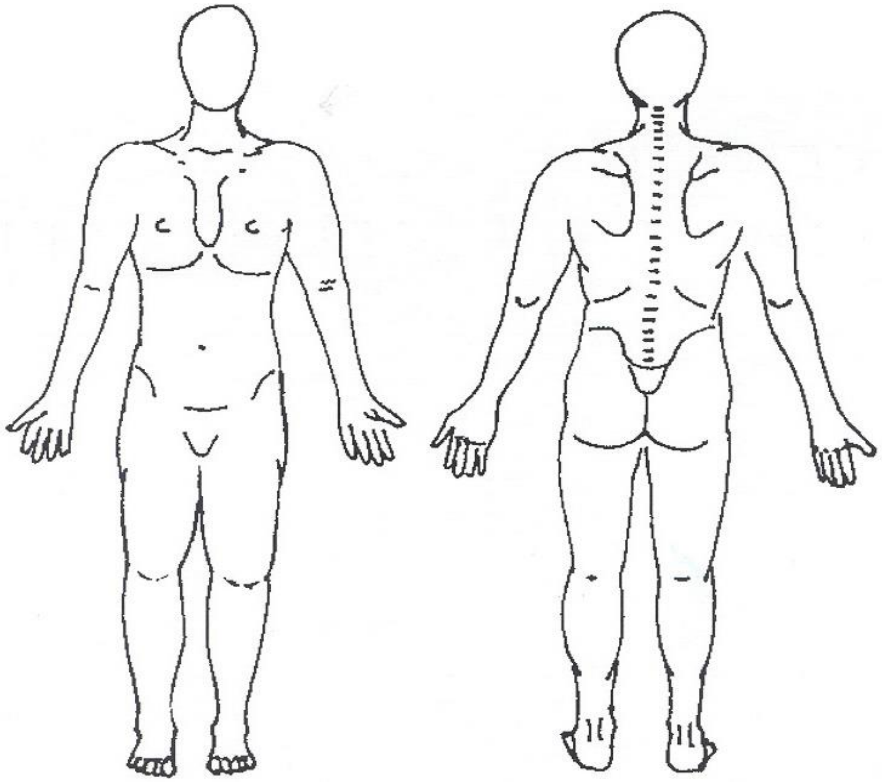
Consititutional	**Cardiovascular**	**Gastrointestinal**	**Neurological**	**Other**
☐ Unexplained weight gain	☐ Heart attack	☐ Change in bowel habits	☐ Numbness	☐ Headaches
☐ Fatigue	☐ Heart murmur	☐ Heart burn	☐ Stroke	☐ Sexually transmitted disease
☐ Trouble sleeping	☐ Cardiopulmonary disease	☐ Stomach ulcers	☐ Seizures	☐ Rheumatic Fever
Respiratory problems	☐ Hernia	☐ Frequent stomach pain	**Genitourinary**	☐ _____
☐ Asthma	☐ Swollen ankles	☐ Vomiting blood	☐ Difficulty urinating	
☐ Shortness of breath	**Joint Problems**	☐ Bloody, or tarry stools	☐ Kidney stones	
☐ Blood clot in lung	☐ Gout	☐ Jaundice	☐ Bladder infection	
☐ Cough	☐ Joint swelling	☐ Hemorrhoids	☐ Kidney infection	
☐ Cough up blood	☐ Joint pain	**Endocrine**		
☐ Bronchitis	☐ back problems	☐ Goiter / thyroid		

Pain Diagram and Rating

Subject ID:_____ Date:_____/_____/_____
mm dd yy

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. **Be VERY precise when drawing the location of your pain.** Use the key to indicate the type of symptoms.

Key: Pins and Needles = 000000 Stabbing = / / / / / /
Burning = xxxxxx Deep Ache = zzzzzz



Please rate your current level of pain on the following scale (check one):

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

How long can you perform the following activities?

Sit _____ min Stand _____ min Walk _____ min