



**LeRoy Physical Therapy, PC
Gananda-Walworth Physical Therapy
Gates-Chili Physical Therapy
MEDICAL SCREENING FORM**

Name _____ *First MI Last* **DOB** ____ / ____ / ____

Address _____ *Street City Zip Code*

Home Phone _____ Cell/Alternate Phone _____

E-mail address _____ Occupation _____

In case of emergency, please notify _____ Relationship _____

Address _____ Phone _____

How did you hear about us? (Please check all that apply)

- Physician recommended/referral
- Friend/relative _____
- Past patient returning for new problem
- From a list my physician gave me
- LeRoy Pennysaver ad
- Village Fitness member
- Website (*www.villagefit.com*)
- Yellow Page Ad
- Television/radio ad
- Saw building/sign
- Athletic Trainer: *school* _____
- Other (please list) _____

Function Questionnaire

Please circle the number that best describes your ability **TODAY**.

1. Rate Your Ability to *Sit*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do
2. Rate Your Ability to *Stand*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do
3. Rate Your Ability to *Walk*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do
4. Rate Your Ability to *Turn and Twist*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do
5. Rate Your Ability to *Stoop and Squat*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do
6. Rate Your Ability to *Bend*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do
7. Rate Your Ability to *Lift and Carry*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do
8. Rate Your Ability to *Reach and Throw*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do
9. Rate Your Ability to *Grip and Grasp*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do
10. Rate Your Ability to *Push and Pull*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do
11. Rate Your Ability to *Participate in Your Normal Sport or Recreational Activities (including hobbies)*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do
12. Rate Your Ability to *Work*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do
13. Rate Your Ability to *Sleep*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do
14. Rate Your *Overall Ability to Perform Your Normal Daily Activities at Work, Home, and Play*:
 Completely **able** to do 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 completely **unable** to do

Name: _____

Date: _____

| Check <u>all</u> boxes that apply... | | |
|---|--------------------------|--------------------------|
| Have you or any immediate family members ever been told you have:..... <u>SELF</u> <u>FAMILY</u> | | |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina/chest pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoarthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatoid arthritis | <input type="checkbox"/> | <input type="checkbox"/> |

| Check <u>all</u> boxes that apply... | |
|---|--------------------------|
| In the past 3 months have you had or do you experience: | |
| A change in <u>your</u> health | <input type="checkbox"/> |
| Nausea/Vomiting | <input type="checkbox"/> |
| Fever/chills/sweats | <input type="checkbox"/> |
| Unexplained weight change | <input type="checkbox"/> |
| Numbness and tingling | <input type="checkbox"/> |
| Changes in appetite | <input type="checkbox"/> |
| Difficulty swallowing | <input type="checkbox"/> |
| Changes in bowel or bladder function | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> |
| Upper respiratory infection | <input type="checkbox"/> |
| Urinary tract infection | <input type="checkbox"/> |
| Pregnancy | <input type="checkbox"/> |

| Check <u>all</u> boxes that apply... | |
|--------------------------------------|--------------------------|
| Do you have a history of: | |
| Allergies/Asthma | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> |
| Kidney disease | <input type="checkbox"/> |
| Rheumatic fever | <input type="checkbox"/> |
| Ulcers | <input type="checkbox"/> |
| Pacemaker | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> |

| |
|---|
| Do you or have you in the past smoked tobacco? |
| Please circle: YES or NO |
| If YES, date of last tobacco use |

| Check <u>all</u> boxes that apply... | |
|--------------------------------------|--------------------------|
| Do you have a problem with: | |
| Hearing | <input type="checkbox"/> |
| Vision | <input type="checkbox"/> |
| Speech | <input type="checkbox"/> |

| Check the <u>most appropriate</u> box... | |
|--|--------------------------|
| How are you able to sleep at night: | |
| Fine | <input type="checkbox"/> |
| Moderate difficulty | <input type="checkbox"/> |
| Only with medication | <input type="checkbox"/> |

| |
|--|
| Please list any surgeries, including dates: |
| _____ |
| _____ |
| _____ |

| |
|---|
| Please list medications you are currently using: |
| _____ |
| _____ |
| _____ |

*** Please fill out the following sections with respect to your current symptoms...**

| Check the <u>most appropriate</u> box... | |
|--|--------------------------|
| Are your symptoms: | |
| Getting worse | <input type="checkbox"/> |
| Staying the same | <input type="checkbox"/> |
| Improving | <input type="checkbox"/> |

| |
|---|
| Date of onset/injury: _____ |
| Date and location of surgery (if applicable): _____ |
| Check all tests you have had below: |
| X-ray <input type="checkbox"/> MRI <input type="checkbox"/> |
| Other _____ |
| What makes your symptoms worse: _____ |
| _____ |
| What makes your symptoms better: _____ |
| _____ |
| _____ |