

CNY PHYSICAL THERAPY MEDICAL SCREENING FORM

DATE: _____

What is the problem that brings you to our office today?

Referring Doctor: _____ Primary care physician _____

How did you hear of CNY Physical Therapy? Doctor Newspaper Other: _____

HAVE YOU HAD or DO YOU HAVE any of the following conditions? (Please X all that applies)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Heart disease/CHF |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Spine / orthopedic surgery |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> kidney disease | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Blood in stool/urine | <input type="checkbox"/> Night pain | <input type="checkbox"/> Tuberculosis |

If you answered, "yes" to any of the above, please explain: _____

Please list **all medications** (including over counter): _____

▶ Have you received Home Healthcare *this year (2010)* (ie: blood draws / nursing / physical therapy)?

Yes

No

Date you were discharged: _____

▶ Have you had physical therapy *elsewhere this year*? Yes No If so, where? _____

Date you were discharged: _____

IN THE EVENT OF AN EMERGENCY WHOM MAY WE CONTACT? _____ Phone _____