Pinnacle Performance, Inc.

Medical Screening Questionnaire

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

NAME: ____ DATE:_______________________________________

OCCUPATION: _____________________________________ LEISURE ACTIVITIES:_________________________

ALLERGIES: List any medication(s) you are allergic to: ____

Are you latex sensitive? Yes No List any other allergies we should know about ______________________

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Please check (√) any of the following whose care you're under

___ Medical doctor (MD)
___ Osteopath
___ Dentist
___ Psychiatrist/Psychologist
___ Physical Therapist
___ Chiropractor
Other ________________
____

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

____

____

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

YES NO Cancer. If YES, describe what kind: ________________
YES NO Heart Problems
YES NO High blood pressure
YES NO Circulation problems
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Chemical dependency (i.e. alcohol, drugs)
YES NO Thyroid problems
YES NO Diabetes
YES NO Multiple sclerosis
YES NO Rheumatoid arthritis
YES NO Other arthritic conditions
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke
YES NO Kidney disease
YES NO Anemia
YES NO Epilepsy
YES NO Osteoporosis/Osteopenia
YES NO Other_______________________________

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Please provide the date and the reason for your surgery/ hospitalization

1.____ 2. ____

3. ____ 4. ____

5.____ 6. ____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
________	________________________	________	________________________
________	________________________	________	________________________

Has anyone in your **IMMEDIATE FAMILY** (parents, brothers, sisters) ever been treated for any of the following?

YES NO Diabetes
YES NO Tuberculosis
YES NO Heart disease
YES NO High blood pressure
YES NO Stroke
YES NO Kidney disease
YES NO Alcoholism (chemical dependency)
YES NO Cancer
YES NO Arthritis
YES NO Anemia
YES NO Headaches
YES NO Epilepsy
YES NO Mental illness

Which of the following **OVER-THE-COUNTER** medications have you taken in the last week?

YES NO Aspirin
YES NO Tylenol
YES NO Advil/Motrin/Ibuprofen
YES NO Laxatives
YES NO Decongestants
YES NO Antihistamines
YES NO Antacid
YES NO Vitamins/mineral supplements
YES NO Herbs
YES NO Other __________________________

How much caffeinated coffee or caffeine containing beverages do you drink per day? _________________

How many packs of cigarettes do you smoke a day? ________

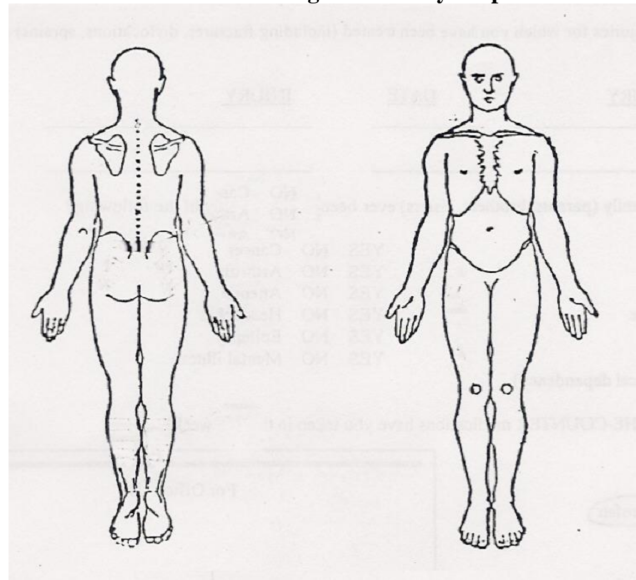
How many days per week do you drink alcohol? ________

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? ____________

Have you recently noted:

YES NO Weight loss/gain
YES NO nausea/vomiting
YES NO fatigue
YES NO weakness
YES NO fever/chills/sweats
YES NO numbness or tingling

Please mark below on the diagram where your pain is:



On a scale from 0 to 10 rate your pain when it is at its:

Best:________ Worst:________

Describe the type of pain you are experiencing:

____

When do you experience the pain?

____

What activities alleviate your pain?

____

What activities aggravate your pain?

____

Has your condition been getting better or worse?

____

Are you currently participating in a regular exercise routine? YES NO If YES, What are you doing?

____

Have you had Physical Therapy in the past for this condition? YES NO If YES, what were the results?

____

What are your goals/expectations from Physical therapy?

____