LILIAN HOLM WELLNESS
PHYSICAL THERAPY AND WELLNESS COACHING

MEDICAL SCREENING QUESTIONNAIRE

Name:____**DOB:**____________**Date:**____

Biological sex: M F Age:_____**Occupation:**______________________**Pregnant: Y N**

All diagnoses and past surgical history:____

____

Current Medications:____

Results of X-ray, MRI or other tests:____

Are you experiencing any of the following? (*circle* any that apply, underline if a close relative (parents, siblings has been diagnosed with any of the following), add others.

Cancer Diabetes Kidney disease Stroke
High blood pressure Heart disease Angina/Chest pain Ulcers
Osteoporosis Osteoarthritis Rheumatoid arthritis Fibromyalgia
Allergies/Asthma Lung disease Liver disease Sexually transmitted disease
Symptoms when looking down Head feeling heavy/wobbly Numbness/electrical sensations

Unexplained weight loss Fever/chills/sweats Bowel or bladder function change (incl.leaking)
Depression Changes in appetite Poor balance/falls Loss of menstrual period
Weakness Nausea/vomiting Difficulty swallowing Shortness of breath
Numbness/tingling Dizziness Night pain Headaches

or pain correlated with eating, fasting, urinating, defecating, sleeping, coughing, breathing, recent travel

Do you take blood thinners? Y N Do you take osteoporosis drugs? Y N
Are you allergic to latex? Y N Have you had a recent illness?Name:________________

CURRENT SYMPTOMS:

Current symptoms and location?____

When, why, how did your symptoms start?

____

My symptoms are currently(circle): getting better /about the same/getting worse

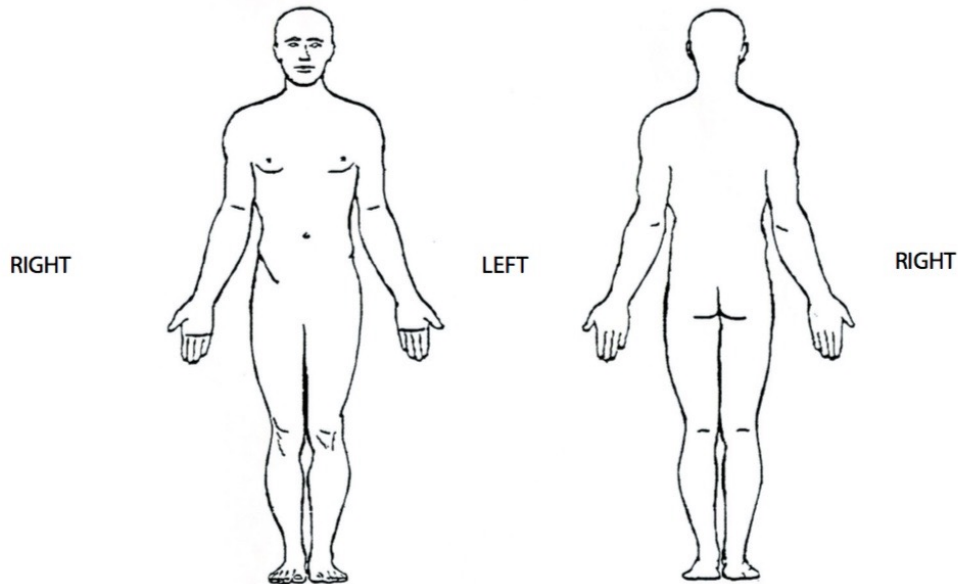
Have you received any treatment for this problem? (please describe type and

outcome):____

Have you had this problem before? If so, please describe duration,treatment, outcome:

____

Please mark the areas where you feel pain on the figure below. Please circle on the scale below the numbers which best represents the average, lowest and worst severity of your pain over the past week.



No pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst imaginable pain

Please mark numbness or tingling with N or T in the area where they occur

Worsens symtoms:____

Improves symptoms:____

Best and worst times of day. Why?____

Long term goal for treatment/ what would you like to be able to do?

____

____

List functional activities you are currently unable to perform, or are severely limited, due

to your symptoms.____

Do you limit activity or avoid certain positions in order to avoid pain or worsening? Y N

Over the past two weeks, have you felt hopeless or depressed, or the loss of interest or pleasure in doing things? Yes No **If yes, do you need to seek help with this?** Yes No