

SULPHUR SPRINGS PHYSICAL THERAPY

HEALTH SCREENING

www.ssphysicaltherapy.com

NAME _____ DATE: _____

DATE OF BIRTH _____

please print

Circle YES or NO

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

Are you currently:

Pregnant? Yes — No

HIV Positive Yes — No

Are your Symptoms?: (check one)

Getting worse The same Improving

How are you able to sleep at night? (check one)

Fine Moderate difficulty Only with medication

Do you have a problem with...(check all that apply)

Hearing Vision
Speech Communication

In the past 3 months have you had or do you experience:

A change in your health?	Yes — No
Unexplained weight change?	Yes — No
Numbness or tingling?	Yes — No
Changes in appetite?	Yes — No
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

Do you walk with or use:

a cane a walker
wheelchair with help from others

Physician: _____

Date of last Physician visit _____

Next Appointment _____

List Medication(s) currently using: _____

Do you have a history of:

Allergies / Asthma?	Yes — No
Headaches?	Yes — No
Bronchitis?	Yes — No
Kidney Disease?	Yes — No
Ulcers?	Yes — No
Seizures?	Yes — No

Circle any test that have been performed:

X-Ray MRI Cat-Scan Myelogram

Arthrogram Bone Scan Discogram Blood Test

Injections

Results: _____

PLEASE SIGN _____