Mercy Clinics, Inc.
Physical Therapy

MEDICAL SCREENING FORM

To ensure you receive a complete and thorough evaluation, please provide us with the most accurate information possible. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

NAME:______________________________ **OCCUPATION**:__________________________________

YOU LEARN BEST BY: ☐ Being told ☐ Being shown ☐ Written directions

Are there **religious**, **spiritual** or **cultural beliefs** that may affect your plan of care?

☐ No ☐ Yes Explain ____

HEIGHT ________ **WEIGHT** ________

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

List any other allergies____

Are you LATEX SENSITIVE? YES NO

Do you feel you are in an abusive relationship? YES NO

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

YES NO Anemia
YES NO Asthma
YES NO Chemical dependency (i.e. alcoholism)
YES NO Circulation problems
YES NO Cancer. If **YES**, what kind:__________
YES NO Diabetes
YES NO Depression
YES NO Emphysema/Bronchitis
YES NO Epilepsy
YES NO Gastrointestinal disorders
YES NO Hepatitis
YES NO Heart problems
YES NO High blood pressure
YES NO Kidney disease
YES NO Multiple sclerosis
YES NO Thyroid problems
YES NO Rheumatoid arthritis
YES NO other arthritic conditions
YES NO Stroke
YES NO Tuberculosis

Is urine leakage a problem for you? YES NO

FOR WOMEN: Are you currently **pregnant** or think you might be **pregnant?** YES NO

Gynecological problems? YES NO

Please list any surgeries, hospitalizations, or injuries, including the approximate date:

DATE SURGERY / HOSPITALIZATION / INJURY

1.__________ ____________________________

2.__________ ____________________________

3.__________ ____________________________

4.________ ________________________________

5.________ ________________________________

6.________ ________________________________

List any PRESCRIPTION medications you are currently taking including pills, injections, and/or skin patches):

1.________________________ 2. ____________________________ 3.__________________________

4.________________________ 5. ____________________________ 6.__________________________

List any OVER-THE-COUNTER medications you have taken in the last week?

1.____________________ 2.___________________ 3.___________________ 4.___________________

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

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

How many days per week do you drink alcohol?____________ **How much per episode**?___________

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

________________________________ ___________________________________

Therapist signature Date