



Personalized PT P.C.

Physical Therapy Screening

Date: _____

Gender: M F Age: ____

Name: _____

Smoker: Y N Pregnant: Y N

Date of Birth: ____ - ____ - _____

Occupation: _____

Do you engage in regular exercise or strenuous activity? _____

CURRENT SYMPTOMS

What are your current symptoms? _____

When (approximately) did your present pain start? _____

How did it start? _____

My symptoms are currently: Getting better / About the same / Getting worse

Have you been treating your problem? If so, how? _____

Have you ever had this problem before: YES / NO

If so, how was the problem treated in the past? _____

How long did it take for you to feel better? _____

Are you able to sleep at night? Yes With Difficulty Only with medication

What is your personal goal for therapy? _____

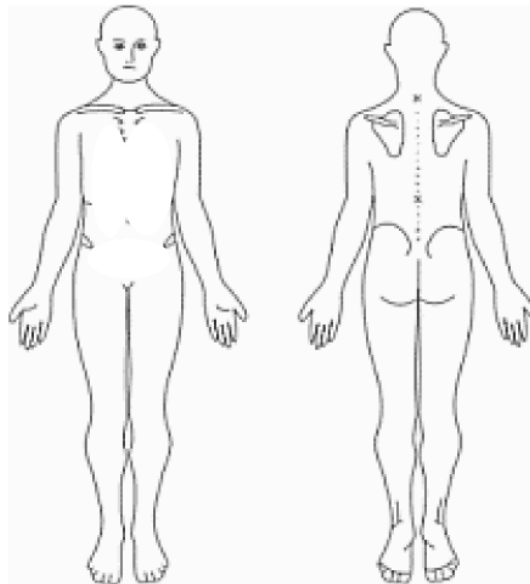
Currently I am experiencing (circle all that apply) : Poor balance (falls) Dizziness Headaches

Nausea /Vomiting Increased pain at night Unexplained weight loss Numbness or Tingling

Fever/chills/sweats Changes in bowel or bladder function Changes in appetite Depression

Shortness of Breath Difficulty with swallowing

Please mark where you feel pain on the figures to the right. And add comments if you wish:



PLEASE TURN OVER

On the scales below, please circle the number which best represents the severity of your pain

Average for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Best for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Worst for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Please circle the number below which best represents your overall average level of function.

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 Able to do everything

What makes your symptoms better? _____

Please circle the activities which make your pain worse: lying down sitting standing walking stress

Any other activities that make your pain worse?:

Please list the best time of day for your symptoms: _____

And worst time of day for your symptoms: _____

Aggravating Factors : Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1) _____

2) _____

3) _____

Have you had an x-ray, MRI, or other imaging study? ___ no ___ yes if so, where? _____

Is there anything else you feel we should know about your history which would make it easier for you to succeed in Physical Therapy?

CONSENT : I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered. _____ (Sign)



www.Personalized-PT.com

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