PHYSICAL THERAPY INSTITUTE OF ILLINOIS

OUTPATIENT SCREENING FORM

Please answer all questions to the best of your ability.

1. Patient Name:

2. Age: 3. Height: 4. Weight:

5. What problem are you being treated for today?

6. When did your problem begin?

7. Are you currently working? *Please circle:* Yes No *Please Circle:* Light Duty Full Duty Not Working

8. What is your occupation?

9. Does your occupation consist of: Sitting Standing Walking - Lifting -

10. Do you have any significant diseases/medical conditions/allergies? *Please circle:* Yes No

11. Are you currently taking any medications? *Please circle:* Yes No

If yes, please list medications

12. Have you ever had an adverse reaction to any medications? *Please circle:* Yes No

13. Do you have any type of heart condition? *Please circle:* Yes No

14. Do you have high blood pressure? *Please circle:* Yes No

15. Have you had any surgeries? *Please circle:* Yes No

If yes, please list:

16. Do you use alcohol? *Please circle:* Yes No

If yes, how frequent?

17. Do you smoke? *Please circle:* Yes No

18. Females: Are you pregnant? *Please circle:* Yes No

19. Is there anything else we should know that is pertinent to your treatment?

20. Have you had any tests or X-Rays? *Please circle:* Yes No

If yes, please explain:

21. Person to contact in case of an emergency, if no one is at your home phone number.

Name: Phone: Relationship:

Patient Signature: Date: