



Medical Screening Form

Name: _____ Date: _____

CURRENT CONDITION:

Where are you currently having symptoms: _____

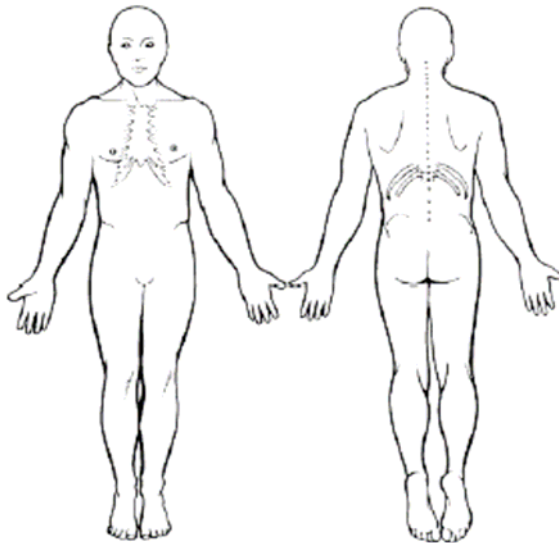
When did these symptoms start? _____

How did this injury occur (gradually, suddenly, injury): _____

My symptoms are currently: Getting Better / About the Same / Getting Worse
Please list any previous treatment for the condition we are seeing you for today? _____

Have you ever had this problem before? YES NO
If so, how was the problem treated? _____

Have you had any imaging studies done for this problem (x-rays, MRI, etc)? YES NO
Please use the following symbols: ^^^ Numbness *** Pins & Needles /// Pain



Rate your pain (1=mild, 10=severe): At its worst: 1 2 3 4 5 6 7 8 9 10 At its best: 1 2 3 4 5 6 7 8 9 10
Right Now: 1 2 3 4 5 6 7 8 9 10

Currently, I am experiencing the following (circle all that apply):

Unexplained Weight Loss
Increased Pain at Night
Fever / Chills / Sweats
Changes in Appetite

Difficulty Swallowing
Headaches
Nausea / Vomiting
Numbness or Tingling

Dizziness
Changes in Bowel or Bladder Function
Depression
Shortness of Breath
Poor Balance / Falls

