LeRoy Physical Therapy, PC
Gananda-Walworth Physical Therapy
Gates-Chili Physical Therapy
MEDICAL SCREENING FORM

Name _____ **DOB**____/____/____
First *MI* *Last*

Address_____
Street *City* *Zip Code*

Home Phone _____ **Cell/Alternate Phone** _____

E-mail address _____ **Occupation** _____

In case of emergency, please notify_____ **Relationship** _____

Address_____ **Phone** _____

How did you hear about us? *(Please check all that apply)*

□ Physician recommended/referral □ LeRoy Pennysaver ad □ Television/radio ad
□ Friend/relative _____ □ Village Fitness member □ Saw building/sign
□ Past patient returning for new problem □ Website *(www.villagefit.com)* □ Athletic Trainer: *school* _____
□ From a list my physician gave me □ Yellow Page Ad □ Other (please list) _____

Function Questionnaire

Please circle the number that best describes your ability **TODAY.**

1. Rate Your Ability to *Sit*:
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do
2. Rate Your Ability to *Stand*:
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do
3. Rate Your Ability to *Walk*:
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do
4. Rate Your Ability to *Turn and Twist*:
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do
5. Rate Your Ability to *Stoop and Squat*:
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do
6. Rate Your Ability to *Bend:*
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do
7. Rate Your Ability to *Lift and Carry*:
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do
8. Rate Your Ability to *Reach and Throw*:
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do
9. Rate Your Ability to *Grip and Grasp*:
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do
10. Rate Your Ability to *Push and Pull*:
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do
11. Rate Your Ability to *Participate in Your Normal Sport or Recreational Activities (including hobbies):*
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do
12. Rate Your Ability to *Work*:
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do
13. Rate Your Ability to *Sleep*:
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do
14. Rate Your *Overall Ability to Perform Your Normal Daily Activities at Work, Home, and Play:*
Completely **able** to do 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 completely **unable** to do

Name: _____ **Date:** _____

Check all boxes that apply…		
Have you or any immediate family members ever been told you have:……..	**SELF**	**FAMILY**
Cancer	☐	☐
Diabetes	☐	☐
High blood pressure	☐	☐
Heart disease	☐	☐
Angina/chest pain	☐	☐
Stroke	☐	☐
Osteoporosis	☐	☐
Osteoarthritis	☐	☐
Rheumatoid arthritis	☐	☐

Check all boxes that apply…	
In the past 3 months have you had or do you experience:	
A change in your health	☐
Nausea/Vomiting	☐
Fever/chills/sweats	☐
Unexplained weight change	☐
Numbness and tingling	☐
Changes in appetite	☐
Difficulty swallowing	☐
Changes in bowel or bladder function	☐
Shortness of breath	☐
Dizziness	☐
Upper respiratory infection	☐
Urinary tract infection	☐
Pregnancy	☐

Check all boxes that apply…	
Do you have a history of:	
Allergies/Asthma	☐
Headaches	☐
Bronchitis	☐
Kidney disease	☐
Rheumatic fever	☐
Ulcers	☐
Pacemaker	☐
Seizures	☐

Do you or have you in the past smoked tobacco?
Please circle: YES or **NO**
If YES, date of last tobacco use_____

Check all boxes that apply…	
Do you have a problem with:	
Hearing	☐
Vision	☐
Speech	☐

Check the most appropriate box…	
How are you able to sleep at night:	
Fine	☐
Moderate difficulty	☐
Only with medication	☐

Please list any surgeries, including dates:

_____
_____
_____
_____

Please list medications you are currently using:

_____
_____
_____
_____
_____

*** Please fill out the following sections with respect to your current symptoms…**

Check the most appropriate box…	
Are your symptoms:	
Getting worse	☐
Staying the same	☐
Improving	☐

Date of onset/injury:_____

Date and location of surgery (if applicable): _____

_____

Check all tests you have had below:

X-ray ☐ **MRI** ☐

Other_____

What makes your symptoms worse: _____

_____

_____

What makes your symptoms better: _____

_____

_____