DynaPeak
Fitness and Physical Therapy

OUTPATIENT SCREENING FORM

Name: _____ Age: _____

What problem(s) are you being treated for today? _____

What date (roughly) did your present symptoms start?_____

How did your problem(s) begin?_____

My symptoms are currently: GETTING BETTER GETTING WORSE STAYING THE SAME

My symptoms currently: COME AND GO ARE CONSTANT ARE CONSTANT, BUT CHANGE WITH ACTIVITY

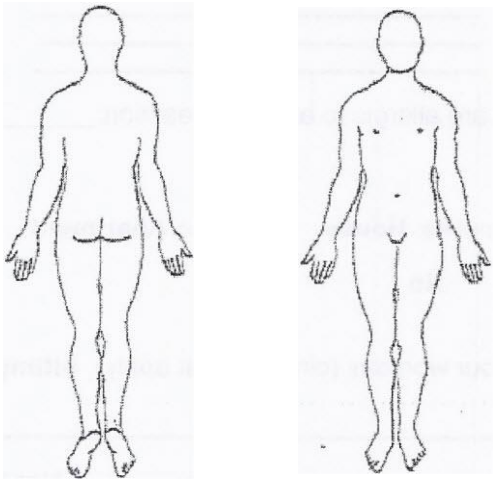
What makes your symptoms *better*:_____

What makes your symptoms *worse*:_____

What time of day are your symptoms worse: MORNING AFTERNOON EVENING OVERNIGHT

Please mark on the body chart the areas where you feel symptoms using the following symbols:

↓ Shooting/Sharp Pain
Dull/Aching Pain
|| || Numbness
≡ Tingling



Treatment received so far for this problem (please circle): Chiropractic Acupuncture Injections ~

Physical/Occupational Therapy Other:_____

Have you received physical/occupational therapy within the last calendar year: YES NO

Approximately how many treatment sessions have you received this calendar year? _____

Indicate special tests performed for this problem and results if known (circle all that apply):

X-ray _____ Bone Scan _____ CT scan _____MR_____

Other: _____ _____ _____ _____

What is your goal for therapy? _____

Date of next physician appointment: _____

MEDICAL HISTORY
Have you recently noted any of the following (check all that apply):

- O Changes in bowel or bladder function
- O Weight loss/gain
- O Shortness of breath
- O Nausea/vomiting
- O Dizziness/lightheadedness
- O Difficulty maintaining balance while walking
- O Headaches
- O Changes in appetite
- O Fever/chills/sweats
- O Pain at night
- O Weakness/fatigue
- O Difficulty swallowing
- O Numbness/tingling

Please list past medical history (i.e., falls, pacemaker, surgeries) including dates (indicate if for current condition):

Please list any allergies (i.e., latex, adhesives): _____ _

For WOMEN: Are you currently or think you might be pregnant? **YES** Number of weeks__ **NO**

During the past month, have you been bothered by feeling down, depressed, or hopeless? **YES** **NO**

During the past month, have you been bothered by having little interest or pleasure in doing things? **YES** **NO**

Is this something with which you would like help? **YES** **YES, BUT NOT TODAY** **NO**

MEDICATIONS
Please provide names of all medications, vitamins, supplements, and over-the-counter drugs you are currently taking. We can copy a detailed list if you have one.

Medication Name	**How much (dose)**	How often	**How taken (circle one)**
			ointment pill drop patch injection inhaler
			ointment pill drop patch injection inhaler
			ointment pill drop patch injection inhaler
			ointment pill drop patch injection inhaler
			ointment pill drop patch injection inhaler

List any medication(s) you are allergic to and your reaction: _____ _

SOCIAL HISTORY
Home:
Please circle choice that applies: **House** **Condo/Apartment** **Group Residence** **Nursing Home**

Do you live alone? **Yes** **No**

Occupation:
What activities comprise your workday (circle all that apply): **Sitting** **Standing**

Other: _____ _____ **Walking Lifting**

Current work status: **Light duty** **Full Duty** **Not Working**

If not working, when was the last time you worked: _____

Leisure Activities/Hobbies/Exercise Routine: _____ _

Do you use tobacco? **YES NO** If yes, indicate type, amount, and frequency: _____ _

Alcohol intake and frequency: _____ _

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

The above information I have supplied is complete, true, and correct to the best of my knowledge.

Patient/Guardian Signature _____ Date _____ _