CARBON CREEK
Physical Therapy
HEAL · EXPLORE · GROW

PHONE 970/901-7684 FAX 970/230-5524 EMAIL bob@carboncreekpt.com WEB carboncreekpt.com
OFFICE 405 W Tomichi · Gunnison, CO 81230 MAILING PO Box 335 · Gunnison CO 81230

Medical Screening Form

Name:_____**DOB:**_____ **Age:**_____

Height:_____ **Weight:**_____ **Primary Care Physician:**_____

☐ I would like to submit an invoice to my insurance or my Flexible Spending Account/ Health Savings Account for personal reimbursement. I will require a coded invoice.

Your overall health right now is (circle): Excellent Very Good Good Fair Poor

Medical History

Please check if you recently had any of the following:
(Clarify responses below as needed)

□ Fatigue
□ Fever/chills/ sweats
□ Weakness
□ Change in mental function
□ Loss of consciousness
□ Any Infection
□ Loss of Balance/ Falls
□ Vomiting/ nausea
□ Numbness/ tingling
□ Cold/cough/ flu
□ Weight change
□ Not feeling well
□ Difficulty swallowing
□ Dizziness/ light headedness
□ Change in bowel/bladder function

Comments:_____
_____
_____
_____

Have you ever been diagnosed with any of the following conditions?

□ Cancer
□ High Blood Pressure
□ Asthma
□ Stroke
□ Epilepsy
□ Stomach aches/ nausea
□ Dizziness
□ Visual Disturbances
□ Prostate problems
□ AIDS/ HIV
□ Constipation
□ Fever/chills/ sweats
□ Weakness
□ Diabetes
□ Heart Attack
□ Tuberculosis
□ Pneumonia/Bronchitis
□ Kidney Stones/Disease
□ Liver Disease/Hepatitis
□ Loss of Balance/Falls
□ Head Trauma
□ Gynecological Disorders
□ Pregnancy
□ Cold/Cough/Flu
□ Osteoporosis/Osteopenia
□ Heart Disease
□ Angina or Chest Pain
□ Shortness of Breath
□ Loss of Consciousness
□ Urinary Tract Infection
□ Fatigue
□ Headaches
□ Bleeding Disorders
□ Change in Ability to Urinate
□ Thyroid Problems
□ Pacemaker
□ Depression/Anxiety
□ Metal Implant please specify:_____
□ Organ Transplant please specify:_____

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Name _____

Life Style

Do you exercise? **YES** **NO**
What types of exercise? _____
How often? _____x/week For how many minutes?_____

Do you smoke tobacco? **YES** **NO** If yes, average cigarettes/day?_____
For women: Are you currently pregnant of think you might be pregnant? **YES** **NO**
During the past month have you been feeling down, depressed or hopeless?_____
During the past month have you been feeling little interest or pleasure in doing things?_____
Is this something with which you would like help? **YES** **YES, but not today** **NO**

Medications

Are you currently taking any blood thinners? **YES** **NO**
Are you currently taking steroids medication (Cortisone, prednisone, dexamethasone, ect.) or inhalers? **YES** **NO**
Please list your current medications with dosages: (INCLUDE: pills, injections, inhalers, and/or skin patches):_____ _____
_____ _____
_____ _____
_____ _____

Surgeries

Please list any surgeries that you have had and the approximate date:

Date	Procedure
_____	_____
_____	_____
_____	_____

Diagnostic Tests

	Date	Significant Results
X-Ray	_____	_____
EMG	_____	_____
MRI/CT	_____	_____
Bone Density	_____	_____
Blood Tests	_____	_____

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What activities or positions make your symptoms worse? What do you do to relieve your symptoms?

_____

_____

_____

_____

_____

_____

What are your personal goals for physical therapy?

_____

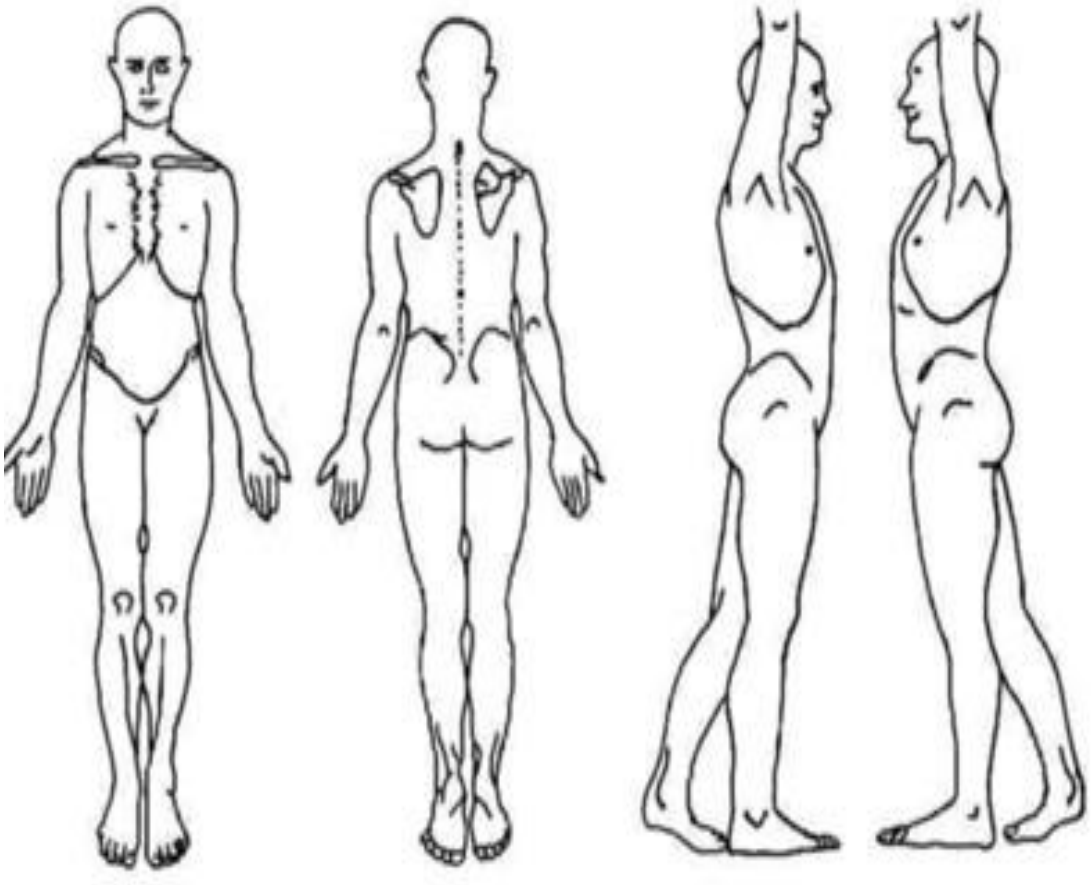
_____

_____

_____

Current Symptoms

Mark areas of current symptoms



Patient Signature_____ **PT Initials**_____

Date_____