Mark Farris Pirtle, DPT, CSCS, COMT

Doctor of Physical Therapy, Certified in Strength and Conditioning and Manual Therapy

General Health Screen

Name:____
(Last) (First)

To insure you receive a complete and thorough examination, please provide me with the important health history information requested on this form. If you do not understand a question please leave it blank and I will assist you. Thank you.

AGE: ____

GENDER: Male ___ Female ___ Are you, or do you think you may be pregnant? Yes___ No___

HANDEDNESS: Right-handed ___ Left-handed ___

Your occupation (past or present):____

Your current employment status:

- ☐ Full-time
- ☐ Part-time
- ☐ Retired
- ☐ Student
- ☐ Homemaker
- ☐ Unemployed
- ☐ Disabled

Are you on modified duty or on temporary leave because of this injury? Yes___ No___

Your leisure activities: ____

Allergies: List any medication(s) you are allergic to: ____

List any other allergies I should know about:

____

Please indicate if you are under the care of any of the following:

MD: ____ DO: ____ Dentist: ____ Psychiatrist/psychologist: ____ PT: ____ Chiropractor: ____ Other: ____

If you have seen any of the above within the past 3 months, please describe the reason: ____________________

____

____

Past Medical History - Please check if you **have** or **ever had:**

☐ Allergies	☐ Low blood sugar/hypoglycemia
☐ Arthritis (any unexplained joint pain?)	☐ Lung problems
☐ Blood disorders	☐ Multiple sclerosis
☐ Bowel or bladder concerns, abnormalities	☐ Muscular dystrophy
☐ Broken bones/fractures	☐ Numbness, tingling or weakness
☐ Cancer	☐ Osteoporosis
☐ Circulation/vascular problems	☐ Parkinson's disease
☐ Depression	☐ Repeated infections (low immunity, **fever**)
☐ Developmental/growth problems	☐ Seizures/epilepsy
☐ Diabetes	☐ Skin diseases
☐ Head injury	☐ Sleep issues or problems
☐ Headaches/migraines	☐ Stroke(s)
☐ Heart problems	☐ Thyroid problems
☐ High blood pressure	☐ Unexplained **fatigue**
☐ Infectious dieases (TB or hepatitis)	☐ Ulcers or stomach problems
☐ Kidney problems	☐ Any other symptoms?

During the past month have you been bothered by feeling down, depressed, or hopeless? Yes ____ No ____
During the past month have you often felt little interest or pleasure in doing things? Yes ____ No ____
Is this something with which you would like help? No ____ Yes, but not today ____ Yes ____
Do you ever feel unsafe at home, or has anyone hit you or tried to injure you in anyway? Yes ____ No ____

Please list **any surgeries or other conditions** for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE:	**REASON FOR SURGERY/HOSPITALIZATION**

Please describe **any significant injuries** for which you have been treated (including fractures, dislocations, sprains) and the approximate date of the injury:

DATE:	**INJURY**

Has anyone in your *immediate* family (parents, brothers or sisters) ever been treated for any of the following:

Diabetes	YES	NO	Who:
Tuberculosis	YES	NO	Who:
Heart disease	YES	NO	Who:
High blood pressure	YES	NO	Who:
Stroke	YES	NO	Who:
Kidney disease	YES	NO	Who:
Alcoholism (chemical dependency)	YES	NO	Who:
Cancer	YES	NO	Who:
Arthritis	YES	NO	Who:
Anemia	YES	NO	Who:
Headaches	YES	NO	Who:
Epilepsy	YES	NO	Who:
Mental illness	YES	NO	Who:

Have you had any of the following medical tests? (Check all that apply)

- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood scan
- ☐ CT scan
- ☐ Discogram
- ☐ Doppler ultrasound
- ☐ Echocardiogram
- ☐ EEG (electroencephalogram)
- ☐ EKG (electrocardiogram)
- ☐ EMG (electromyogram)
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ NCV (nerve conduction velocity)
- ☐ Pulmonary function test
- ☐ Spinal tap
- ☐ Stress test
- ☐ X-rays
- ☐ Other ______________________________

Health Habits:

A. **Exercise** (beyond normal activities)

- ☐ Yes. Describe exercise. ______________________________

  How many days/ hours per week (average)? ______________________________
- ☐ No. I do not engage in regular exercise.

B. Smoking

- ☐ Yes. How much? ______________________________
- ☐ Not any more. When did you quit? ______________________________
- ☐ No, I've never smoked.

C. Alcohol

- ☐ On average, how many drinks do you consume per week (one beer = 1 drink)? _____

  How many at an average sitting? _______
- ☐ I do not drink any alcohol.

D. Caffeinated beverages

- ☐ How many caffeinated beverages do you consume per week (one coffee = 1 drink)? _____

  How many at an average sitting? _______
- ☐ I do not drink caffeinated beverages.

How would you characterize your **General Health?** ☐**Excellent** ☐**Good** ☐**Fair** ☐**Poor**

Please list any **PRESCRIPTION medication** you are currently taking (including pills, injections, patches)

____

Please list <u>all</u> **over-the-counter medication** you have taken in the last week? (e.g. Advil, Aleve, antacids, antihistamines, aspirin, decongestants, herbals, etc.)

____

____

What activities are you ***not able to do now*** that you *could do before* your problem(s) started?

____

____

What are ***your goals*** for Physical Therapy?

____

____

Signature______________________________ Date__________________