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:_____

_____

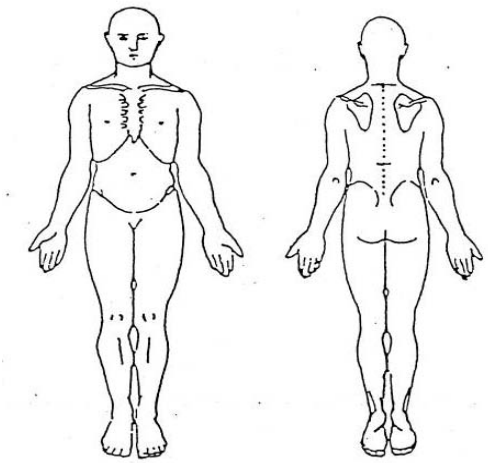
Have you ever had this problem before? **YES** **NO**

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):

Dizziness	Unexplained Weight Loss	Poor Balance / Falls
Depression	Changes in Bowel or Bladder Function	Difficulty Swallowing
Fever / Chills / Sweats	Nausea / Vomiting	Headaches
Shortness of Breath	Changes in Appetite	Increased Pain at Night
		Numbness or Tingling