

**ALEGENT Health PHYSICAL REHABILITATION CLINICS  
MEDICAL HISTORY AND SCREENING CHECKLIST**

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please check below if you currently have, or have had a history of the following:**

High Blood Pressure	_____	Headaches	_____
Cardiac History	_____	Dizziness/Fainting	_____
Pacemaker	_____	Multiple Sclerosis	_____
Stroke	_____	Muscular Dystrophy	_____
Circulation disorder / blood clots	_____	Current/recent pregnancy	_____
Bowel/bladder incontinence	_____	Smoking	_____
Diabetes	_____	Prior Neck/Back problems	_____
Asthma	_____	Major joint injuries	_____
Respiratory illness / Lung disease	_____	Osteoporosis	_____
Hepatitis/Tuberculosis	_____	Arthritis	_____
Cancer	_____	Latex Sensitivity (reaction to rubber products IE balloons, gloves etc..) _____	
Seizure	_____		
Other (explain) _____			

**Surgeries**

\_\_\_\_\_

\_\_\_\_\_

**Check the types of medications you are currently taking:**

_____ Pain Medication	_____ Muscle Relaxants	_____ Anti-Inflammatory
_____ Hypertension	_____ Diabetic	_____ Cardiac

**Please list any Allergies:**

\_\_\_\_\_

\_\_\_\_\_

**Learning Preference:** Demonstration: \_\_\_\_\_ Written materials \_\_\_\_\_

Preferred spoken Language \_\_\_\_\_

Visually impaired Y N                      Hearing impaired Y N

\_\_\_\_\_

Please list any goals you would like to achieve during physical therapy treatment

1. \_\_\_\_\_

2. \_\_\_\_\_

**Pain rating today:**

(Please refer to chart below and circle one)

