

ProCore Physical Therapy

Integrated Core Training for Orthopedic and Sports Rehab

Outpatient Medical History/Screening Form

Patient: _____ Family Physician/Internist: _____

Emergency Contact: _____ Telephone #: _____

How did you hear of Procore Physical Therapy? _____

MEDICAL INFORMATION: TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE/HAVE HAD:

- | | | | | | |
|------------------------------------|-----|----|---|-----|----|
| 1. High Blood Pressure | yes | no | 25. Thyroid Problems | yes | no |
| 2. Chest Pains/Angina/Heart Attack | yes | no | 26. Polio/Muscle Disease | yes | no |
| 3. High Cholesterol | yes | no | 27. Seizures | yes | no |
| 4. Pacemaker | yes | no | 28. Chronic/Migraine Headaches | yes | no |
| 5. Shortness of Breath | yes | no | 29. TMJ Disorders | yes | no |
| 6. History of Smoking | yes | no | 30. Chills/Fevers Sweats | yes | no |
| 7. Lung Problems | yes | no | 31. Swelling of Extremities | yes | no |
| 8. Emphysema/Asthma | yes | no | 32. Osteoporosis | yes | no |
| 9. Bleeding/Bruising | yes | no | 33. Depression | yes | no |
| 10. Anemia | yes | no | 34. Fibromyalgia | yes | no |
| 11. Diabetes | yes | no | 35. Chronic Fatigue Syndrome | yes | no |
| 12. Hypoglycemia | yes | no | 36. Lyme's Disease | yes | no |
| 13. Lightheadedness/Dizziness | yes | no | 37. Cancer/Tumors/Growths | yes | no |
| 14. Blood Disorders | yes | no | 38. Are you pregnant? | yes | no |
| 15. Concussion | yes | no | 39. Gynecological Disorders | yes | no |
| 16. Fainting Disorders | yes | no | 40. Bladder Incontinence | yes | no |
| 17. Anxiety/Panic Attacks | yes | no | 41. Bowel Incontinence | yes | no |
| 18. Arthritis/Joint Pain | yes | no | 42. Diarrhea/Nausea/Vomiting | yes | no |
| 19. Artificial Joints | yes | no | 43. Unexplained Weight Loss >10 lbs./last30days | yes | no |
| 20. Kidney Disease/Stones | yes | no | 44. UNDER 18 ONLY: | | |
| 21. Hepatitis | yes | no | Immunizations Current | yes | no |
| 22. Spinal Cord Injury | yes | no | | | |
| 23. Traumatic Brain Injury | yes | no | | | |
| 24. Fractures: | | | | | |

Date: _____ Area: _____
 Date: _____ Area: _____

45. Rate your Pain 0-10
 (none) 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 (unbearable)

CURRENT MEDICATIONS: _____

ALLERGIES:
 A. To Medications: _____
 B. To Other Substances: _____

SURGERY(S) Include Dates: _____

X-RAYS, MRI, CAT SCAN (Include Area & Dates): _____

What Are Your Treatment Goals? _____

Patient Signature _____ Date: _____

Relationship if other than patient/ Parent/ Guardian if Minor _____

This information will be used as a guide in your treatment plan. If you need any medical follow-up, please contact your physician.