Paula Czapla Physical Therapy, LLC

Paula Czapla PT, DPT

Physical Therapist

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Outpatient Medical History/ Screening

Patient Name: _____ Family Physician/ Internist: _____

Telephone: (_____)-_____-_____

Primary Concern:_____ Height_____ Weight_____

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	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>30lbs./last 30 days	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	45.	Other:	
23.	Traumatic Brain Injuries	yes no		_____	
24.	Fractures:				
	Date: _____Area:_____				
	Date: _____Area:_____				

Pain: (Scale of 0-10)

Today: _____ Best: _____ Worst: _____

Pain location: _____ Pain description: _____

Current Limitations:

Mobility_____ Self Care: _____ Other:_____

Aggravating Factors:

_____

Patient Goals:

_____

General Health:

_____

Current Medications: _____

Allergies:

A. **To Medications:**_____

B. **To Other Substances:**_____

SURGERY(S) Include Dates: _____

XRAYS, MRI, CAT SCAN (Include area & Dates):_____

Patient Signature: _____ Date:_____

Relationship if other than patient: _____