Medical Screening Form

Please answer all of the questions below as fully as you can. If you have any difficulty or doubt in relation to the answer to any question, please discuss with your therapist. All information provided will be treated in the strictest confidence. Your signature on this form indicates that the information provided by you is true and accurate to the best of your knowledge.

About You

Full Name:

Address:

Telephone:

Email:

Date of Birth:

Occupation:

About Your Condition

Main Reason for your appointment:

Areas of complaint, pain or tension:

When did you first notice this complaint?

Is this complaint getting ....

Better **Worse** **Same**

Is the condition interfering with

Your work : **Your sleep :** **Your daily routine :**

What have you done to obtain relief ?

Has there been a medical diagnosis ? **Yes:** **No:**

If yes, what is the diagnosis offered ?

Have you been hospitalised with this ? **Yes:** **No:**

If yes, when, and at which hospital ?

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Medical Screening Form

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About Your Condition

Are you currently under the care of a GP for this condition ? **Yes:** ☐ **No:** ☐ If yes, please provide GP details.

NAME

CONTACT NUMBER

About Your General Health

Are you taking any medication ? **Yes:** ☐ **No:** ☐ If yes, please list which medications.

Have you had any surgery ? **Yes:** ☐ **No:** ☐ If yes, what and when ?

Have you ever broken bones ? **Yes:** ☐ **No:** ☐ If yes, which and when ?

If you have ever been involved in a vehicular or other traumatic accident, please describe the direction and type of impact and when the accident occurred.

Please indicate which of the following, if any, apply to you:

Allergies:	☐	**Arthritis:**	☐	**Blood Clots:**	☐	**Diabetes:**	☐	**Dizziness:**	☐
Headache:	☐	**Heart Problems:**	☐	**High Blood Pressure:**	☐	**Joint Disease:**	☐	**Low Blood Pressure:**	☐
Open lesions:	☐	**Pregnant / Post Natal:**	☐	**Spinal Problems:**	☐	**Skin Problems:**	☐	**Varicose Veins:**	☐

Other (Specify:)

About Your General Lifestyle

Do you exercise or play sport ? **Yes:** ☐ **No:** ☐ If yes, how and how often :

Do you wear contact lenses ? **Yes:** ☐ **No:** ☐

Do you wear dentures or braces ? **Yes:** ☐ **No:** ☐

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Medical Screening Form

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About Your General Lifestyle

Do you feel that you eat a balanced diet ? **Yes:** ☐ **No:** ☐

Rate your consumption of the following :

	High	Moderate	Light	None
Alcohol:	☐	☐	☐	☐
Sugar:	☐	☐	☐	☐
Caffeine:	☐	☐	☐	☐
Tobacco:	☐	☐	☐	☐

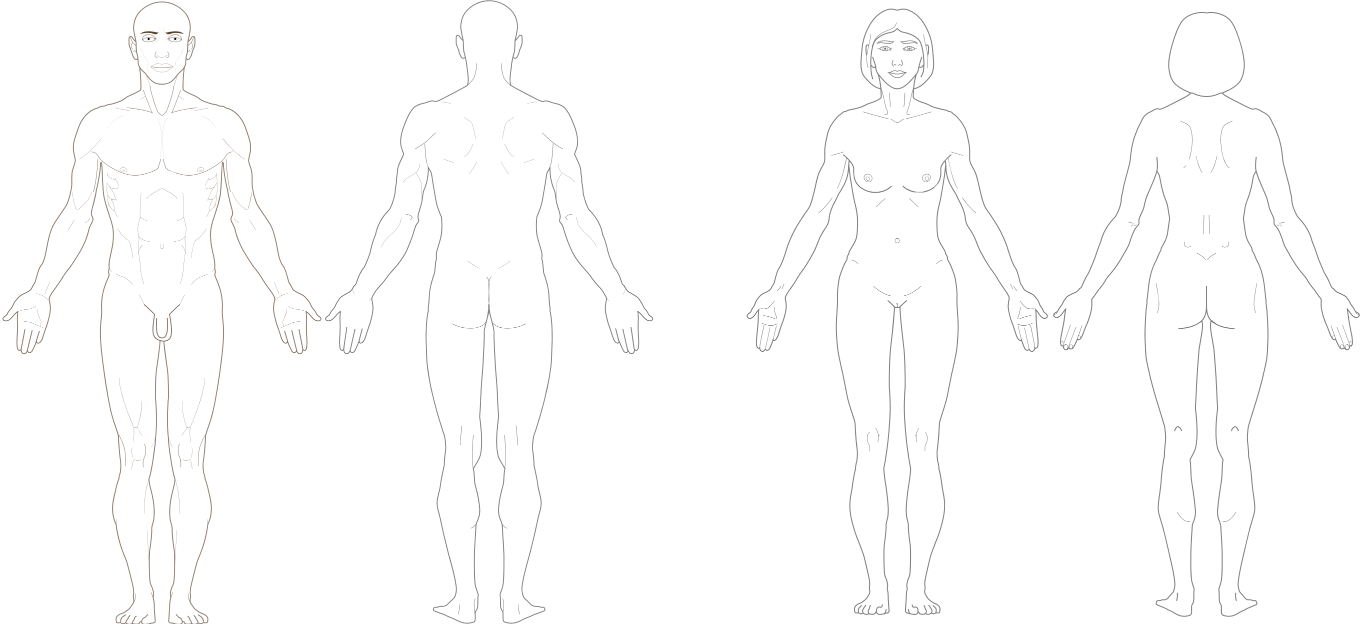
Please describe your stress level :

High	Moderate	Light	None
☐	☐	☐	☐

Do you wear orthotic inserts ? **Yes:** ☐ **No:** ☐ If yes, for how long:

Visual Indication of Condition

Please indicate your areas of complaint by marking them on the figures below:



Please indicate the level of pain, if any, by shading the appropriate number below. 1 indicates very slight pain while 10 indicates severe pain.

1 2 3 4 5 6 7 8 9 10

Name any area you do **NOT** want treated :

Signature:

Date:

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Patient Treatment Record

Patient Name:

Date	Therapist	Treatment Details

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