SALAM FREE CLINIC
1823 McCall Drive, Anniston, AL 36207 Tel: (256) 419-2041

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? _____

_____

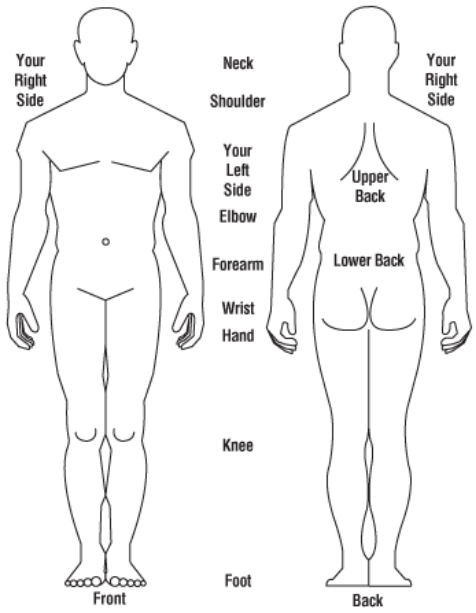
Have you ever had this problem before? ☐ Yes ☐ No

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 is 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 (check all that apply):

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

PAST MEDICAL HISTORY:

Please check any condition that you currently have or have had in the past:

□ High Blood Pressure	□ Stroke	□ Arthritis
□ Lung Disease / Problems	□ Cancer	□ Kidney Disease
□ Heart Disease / Problems	□ Diabetes	□ Liver Disease
□ Asthma / Allergies	□ Pacemaker	□ Angina
□ Circulation / Bleeding Problems	□ Osteoporosis	□ Fibromyalgia

Are you allergic to latex? □ Yes □ No
Do you smoke? □ Yes □ No
Are you pregnant? □ Yes □ No

During the past month, have you often been bothered by feeling down, depressed or hopeless? □ Yes □ No
During the past month, have you often been bothered by little interest or pleasure in doing things? □ Yes □ No

Are you currently taking any medications? □ Yes □ No
If yes, please list ALL medications you are currently taking: _____
_____
_____
_____

Please list past surgeries and dates:
_____
_____
_____
_____

Please list any medical conditions you have that have not been documented above:
_____
_____
_____
_____

What are your physical therapy and / or fitness goals?
_____
_____
_____
_____

Patient Signature: _____ **Date:** _____

OFFICE USE:

Blood Pressure: _____ **Heart Rate:** _____ **Date:** _____