Advanced Manual Therapy Institute

Jody L. Stafford, PT, DPT, MOT, MTC, CEAS | Michel S. Rantissi, PT, DPT, MOT, MTC

2625 West Horizon Ridge Parkway, Suite 120, Henderson, NV 89052
911 North Buffalo Drive, Suite107, Las Vegas, NV 89128

Phone: 702-896-0383
Fax: 702-889-0383

Medical Screening Questionaire

Answering the following questions will help us to manage your care better. Some of the questions may seem like they do not apply to your condition, but your activities of daily life affect your rehabilitation. Please complete all pages prior to your appointment. If you need additional room, please use the last page of this form or the back. Thank You.

Name: ______________________ Date: ____________

Date of Birth: ________ Age: ______ Height: ______ Weight: _______ Doctor: ____________

Emergency Contact Information Name: ______________________ Phone: ____________

What is your primary concern for today's visit? ______________________

Special tests doctor has performed for your condition: ______________________

Last doctor visit? ______________________

Do you now have or have you had a history of the following? Explain yes responses and include dates.

Medical History

Y/N	Cancer - Type: ________	Y/N	Diabetes	Y/N	HIV/AIDS
Y/N	Heart Disease	Y/N	Multiple Sclerosis	Y/N	Epilepsy
Y/N	High Blood Pressure	Y/N	Rheumatoid Arthritis	Y/N	Allergies - List: ________
Y/N	Pacemaker/Defibulator	Y/N	Osteoporosis	Y/N	Allergic to Latex
Y/N	Stroke	Y/N	Osteopenia	Y/N	Low Back Pain/Sciatica
Y/N	Circulation Problems (CVI/Blood Clots)	Y/N	Other Arthritic Conditions	Y/N	Joint Problems
Y/N	Asthma	Y/N	Depression	Y/N	Broken Bones
Y/N	Emphysema/Bronchitis	Y/N	Hepatitis	Y/N	Sexually Transmitted Diseases
Y/N	Smoking Habits	Y/N	Tuberculosis	Y/N	Pelvic Pain
Y/N	Chemical Dependency (alcohol, drugs)	Y/N	Kidney Disease	Y/N	Abdominal Pain
Y/N	Thyroid Problems	Y/N	Anemia	Y/N	Pelvic Trauma

Have you recently noted:

Y/N	Weight Loss/Gain	Y/N	Fatigue	Y/N	Fever/Chills/Sweats
Y/N	Nausea/Vomiting	Y/N	Weakness	Y/N	Numbness or Tingling

Explaination of above YES responses: ______________________

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During the past months have you been feeling down, depressed or hopeless? YES NO
During the past months have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Medications

Which of the following **OVER-THE-COUNTER** medications have you taken in the last week?

Y/N	Aspirin	Y/N	Laxatives	Y/N	Antacid
Y/N	Tylenol	Y/N	Decongestants	Y/N	Vitamins/Mineral Supplements
Y/N	Advil/Motrin/Ibuprofen	Y/N	Antihistamines	Y/N	Other: ________

List any **PRESCRIPTION** medication you are currently taking (including pills, injections and or skin patches):

1. ________ 2. ________ 3. ________

4. ________ 5. ________ 6. ________

7. ________ 8. ________ 9. ________

How much caffeinated coffee or caffeine-containing beverages do you drink per day? ____________
How many packs of cigarettes do you smoke a day? ________ How many days per week do you drink alcohol? ________
If one drink equals one beer or glass of wine, how much do you drink in an average sitting? ____________

Surgical History

Y/N	Surgery for your back/spine	Y/N	Orthopedic Surgeries	Y/N	Surgery for bladder
Y/N	Surgery for your brain	Y/N	Surgery for abdominal organs	Y/N	Surgery for Prostate
Y/N	Other type please describe				

Explaination of above YES responses ______________________________

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Urologic History

Y/N	Trouble initiating urine stream	Y/N	Frequent urination	Y/N	Blood in urine
Y/N	Trouble emptying bladder	Y/N	Pain with urination	Y/N	Bladder infections
Y/N	Excessive urges to empty bladder	Y/N	Incontinence	Y/N	Vaginal dryness
Y/N	Trouble feeling bladder fullness	Y/N	Childhood bladder problem	Y/N	Bladder cancer
Y/N	Constant dribbling of urine	Y/N	Bed wetting		

Explaination of above YES responses ______________________________

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Bowel History

Y/N	Irritable bowel syndrome	Y/N	GI problems	Y/N	Constipation
Y/N	Hemorrhoids	Y/N	Difficulty eliminating	Y/N	Trouble holding back gas
Y/N	Fecal incontinence/leaking	Y/N	Rectal pain	Y/N	Blood in stool

Explaination of above YES responses ______________________________

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OB/Gyn History (Female only) if applicable

Y/N	Painful periods	Y/N	Prolapse of falling out feeling	Y/N	Are you Pregnant?_____weeks
Y/N	Date last period __________	Y/N	Painful penetration	Y/N	Vaginal deliveries # ______
Y/N	Endometriosis	Y/N	upon entry	Y/N	Episiotomy # ______
Y/N	Cysts	Y/N	deep	Y/N	C-section # ______
Y/N	Menopause	Y/N	positional	Y/N	Difficult childbirth

Explaination of above YES responses ______________________________

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Relevant History (Male only) if applicable

Y/N	Prostatitis	Y/N	Scrotum pain	Y/N	Surgery
Y/N	Penile Pain	Y/N	Rectal pain	Y/N	Pain with ejaculation

Explaination of above YES responses ______________________________

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Please list any other concerns or comments you have:

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____

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______________________________ ______________________________

Therapist Signature Date

McGill Pain Questionaire

What Does Your Pain Feel Like?

Statement: Some of the following words below describe your present pain. Circle ONLY those words that best describe it. Leave out any category that is not suitable. Use only a single word in each appropriate category - the one that applies best.

1.

Flickering 1
Quivering 2
Pulsing 3
Throbbing 4
Beating 5
Pounding 6

2.

Jumping 1
Flashing 2
Shooting 3

3.

Pricking 1
Boring 2
Drilling 3
Stabbing 4
Lancinating 5

4.

Sharp 1
Cutting 2
Lacerating 3

5.

Pinching 1
Pressing 2
Gnawing 3
Cramping 4
Crushing 5

6.

Tugging 1
Pulling 2
Wrenching 3

7.

Hot 1
Burning 2
Scalding 3
Searing 4

8.

Tingling 1
Itchy 2
Smarting 3
Stinging 4

9.

Dull 1
Sore 2
Hurting 3
Aching 4
Heavy 5

10.

Tender 1
Taut 2
Rasping 3
Splitting 4

11.

Tiring 1
Exhausting 2

12.

Sickening 1
Suffocating 2

13.

Fearful 1
Frightful 2
Terrifying 3

14.

Punishing 1
Gruelling 2
Cruel 3
Vicious 4
Killing 5

15.

Wretched 1
Blinding 2

16.

Annoying 1
Troublesome 2
Miserable 3
Intense 4
Unbearable 5

17.

Spreading 1
Radiating 2
Penetrating 3
Piercing 4

18.

Tight 1
Numb 2
Drawing 3
Squeezing 4
Tearing 5

19.

Cool 1
Cold 2
Freezing 3

20.

Nagging 1
Nauseating 2
Agonizing 3
Dreadful 4
Torturing 5

Score: /78

Where is your pain?

Please mark on the drawings below the areas where you feel your pain: