Click to RESET Document

Click to Save Document | Click to Print Document

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

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

Have you recently noted:

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

Explanation of above YES responses: _____

_____

_____

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

Medications

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

O Y/N O Aspirin	O Y/N O Laxatives	O Y/N O Antacid
O Y/N O Tylenol	O Y/N O Decongestants	O Y/N O Vitamins/Mineral Supplements
O Y/N O Advil/Motrin/Ibuprofen	O Y/N O Antihistamines	O Y/N O 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 Surgery for your brain
Y/N Other type please describe
Y/N Orthopedic Surgeries
Y/N Surgery for abdominal organs
Y/N Surgery for bladder
Y/N Surgery for Prostate

Explanation of above YES responses _____

Urologic History

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

Explanation of above YES responses _____

Bowel History

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

Explanation of above YES responses _____

OB/Gyn History (Female only) if applicable

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

Explanation of above YES responses _____

Relevant History (Male only) if applicable

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

Explanation of above YES responses _____

Please list any other concerns or comments you have:

_____

_____

_____

_____

_____

_____ _____

Therapist Signature Date

Reset All Pain Choices

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.

Reset Pain Choice #1

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

2.

Reset Pain Choice #2

Jumping	1
Flashing	2
Shooting	3

3.

Reset Pain Choice #3

Pricking	1
Boring	2
Drilling	3
Stabbing	4
Lancinating	5

4.

Reset Pain Choice #4

Sharp	1
Cutting	2
Lacerating	3

5.

Reset Pain Choice #5

Pinching	1
Pressing	2
Gnawing	3
Cramping	4
Crushing	5

6.

Reset Pain Choice #6

Tugging	1
Pulling	2
Wrenching	3

7.

Reset Pain Choice #7

Hot	1
Burning	2
Scalding	3
Searing	4

8.

Reset Pain Choice #8

Tingling	1
Itchy	2
Smarting	3
Stinging	4

9.

Reset Pain Choice #9

Dull	1
Sore	2
Hurting	3
Aching	4
Heavy	5

10.

Reset Pain Choice #10

Tender	1
Taut	2
Rasping	3
Splitting	4

11.

Reset Pain Choice #11

Tiring	1
Exhausting	2

12.

Reset Pain Choice #12

Sickening	1
Suffocating	2

13.

Reset Pain Choice #13

Fearful	1
Frightful	2
Terrifying	3

14.

Reset Pain Choice #14

Punishing	1
Gruelling	2
Cruel	3
Vicious	4
Killing	5

15.

Reset Pain Choice #15

Wretched	1
Blinding	2

16.

Reset Pain Choice #16

Annoying	1
Troublesome	2
Miserable	3
Intense	4
Unbearable	5

17.

Reset Pain Choice #17

Spreading	1
Radiating	2
Penetrating	3
Piercing	4

18.

Reset Pain Choice #18

Tight	1
Numb	2
Drawing	3
Squeezing	4
Tearing	5

19.

Reset Pain Choice #19

Cool	1
Cold	2
Freezing	3

20.

Reset Pain Choice #20

Nagging	1
Nauseating	2
Agonizing	3
Dreadful	4
Torturing	5

Score: 0 /78

Click to Save Document

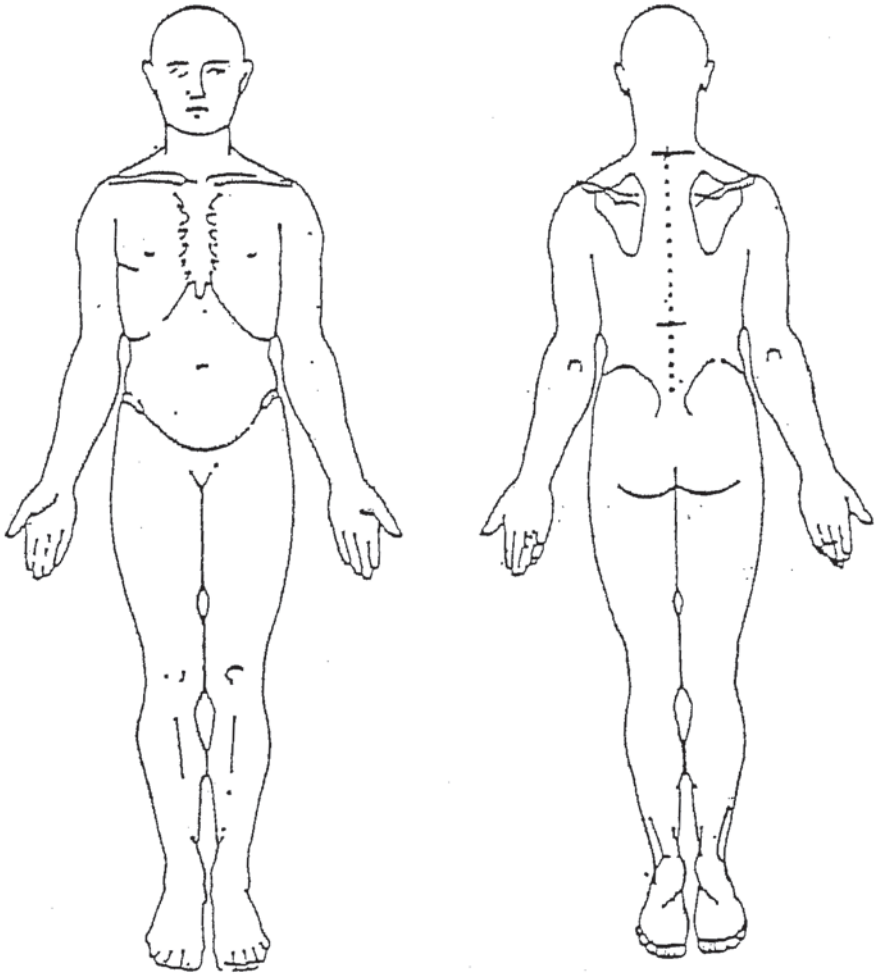
This page is not clickable or fillable.

Please print this page with the rest of the document and use a pen or pencil to fill in the areas where you are having pain.

Click to Print Document

Where is your pain?

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



This page is not clickable or fillable.

Please print this page with the rest of the document and use a pen or pencil to fill in the areas where you are having pain.