Whatcom Community Physical Therapy, LLC

Medical Screening Intake Questionnaire

Patient's Name: _____

Chief Complaint or Medical Diagnosis: _____

Date of Injury or onset of symptoms: _____

Have you received Medical or other care for this condition? Yes / No (Please Circle)

If yes, When and Where? _____

Medical History

Please check the following that apply:

- ☐ Cardiac Pathology: _____
- ☐ Diabetes: Medications? _____
- ☐ Cancer: Treatment? _____
- ☐ Hypertension: Medications? _____
- ☐ High Cholesterol: Medications? _____
- ☐ Surgical History: _____

  _____
- ☐ Other: _____
- ☐ Diagnostic Imaging (X-ray, MRI, CT Scan, Other): Please enter the Date and Location

  _____
- ☐ Other Medications: _____

Patient/Guardian Name:_____ Patient/Guardian Signature:_____

Date:_____