

# ADVANCED MANUAL THERAPY INSTITUTE

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## Medical Screening Questionnaire

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/Defibrillator	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

Explanation of above YES responses: \_\_\_\_\_

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				

Explanation of above YES responses \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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		

Explanation of above YES responses \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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

Explanation of above YES responses \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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

Explanation of above YES responses \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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

Explanation of above YES responses \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list any other concerns or comments you have:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

## McGill Pain Questionnaire

### 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:

