

# Physical Therapy Medical Screening Questionnaire

Name: \_\_\_\_\_ Gender: M F Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Hand Dominance: R L Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

## Past Medical History

Relevant past surgical or hospitalization history:

Please list all current medications:

PT 1000

Adv [redacted]

Patient Identification