



St. Charles Sports & Physical Therapy

MODALITY SCREENING QUESTIONNAIRE

Patient Name: _____

Allergies: (circle all that apply): **Adhesive, Latex, Medications (please list):** _____

Next appointment with your physician _____ Surgery Date: _____

Have you received home health care or physical therapy from any other facility within the past 3 months? YES NO

Are you currently, or have you been treated by a chiropractor in the past 12 months? YES NO

1. Do you or have you had any type of cancer/tumors? YES NO
If so, where and when? _____

2. Do you have any of the following diseases/disorders?
a. Diabetes YES NO
b. High blood pressure YES NO
c. History of heart trouble or heart attacks YES NO
d. Rheumatoid arthritis YES NO
e. Osteoporosis YES NO
f. Peripheral vascular disease or history of blood clots YES NO
g. Other _____ YES NO

3. Have you had any of the following surgical procedures?
a. Metal implant (i.e.. total knee replacement) YES NO
b. Pacemaker placement YES NO
c. Laminectomy (spinal surgery) YES NO

4. Do you have any healing fractures? YES NO
If so, where and when _____

5. Are you currently pregnant? YES NO

6. Do you have any type of existing infection? YES NO
If so, where and when _____

7. Any other important past medical history you feel is relevant?

8. Are you taking any medications? YES NO
If so, name and for what condition _____

I certify the above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____