APTA Maryland
A Chapter of the American Physical Therapy Association

Community Health Screening

NAME: _____

DATE: _____ TIME:_____ AGE: _____

Chief Complaint: _____

General Observation:_____

PMH: _____

_____

Meds: _____

SYSTEMS REVIEW

Pulse Oximetry Saturation: _____% **Blood Pressure** (Arm: ☐ L ☐ R): _____ mmHg

Have you recently experienced any of the following?

- ☐ Trauma (e.g. a motor vehicle accident, a fall)
- ☐ Abnormal sensations (e.g. numbness, pins and needles)
- ☐ Changes in bowel and bladder or any unexplained weight loss or gain.
- ☐ Headaches
- ☐ Night pain
- ☐ Light-headedness
- ☐ Night sweats
- ☐ Constipation
- ☐ Easy bruising
- ☐ Changes in vision
- ☐ Sustained morning stiffness

Issue:_____

_____

O Yes
- ☐ How long ago?
- ☐ How have you managed it so far?

O No

ROM: ☐ NT _____

_____

Strength: ☐ NT _____

_____

Balance: ☐ NT _____

_____

Gait/Mobility: ☐ NT ☐ Currently uses assistive device (type) _____

TUG_____ sec 30 Second Chair Stand Test_____ reps

_____

_____

Pelvic: □ NT _____

_____

Do you experience pelvic pain (in genitals, perineum, pubic, or bladder area, or pain with urination?
- O Yes
- O No

Do you experience any of the following urinary symptoms:
- ☐ Accidental loss of urine
- ☐ Feeling unable to completely empty my bladder
- ☐ Having to void within a few minutes of a previous void
- ☐ Pain or burning with urination
- ☐ Difficulty starting or frequent stopping/starting of urine stream

PAIN, FALL, INJURY HISTORY

Issue:_____

_____

- O Yes
  - ☐ How long ago?
  - ☐ How have you managed it so far?
- O No

PHYSICAL ACTIVITY HABITS

On AVERAGE, how many days each week do you do some physical activity?
- O 3 - 7 days a week
- O 1 - 2 days a week

What activities do you **usually** participate in? _____

_____

O **No regular activity program**

Why aren't you physically active?

- ☐ No available exercise facilities
- ☐ No interest
- ☐ Physically unable
- ☐ No transportation
- ☐ No fitness person to help me
- ☐ No one to exercise with
- ☐ No money
- ☐ Not safe
- ☐ No equipment or clothes

Other: _____

_____

Recommendations: _____

_____

_____PTA_____(MD License#)

_____PT _____(MD License#)


0
NO HURT
1
HURTS
LITTLE BIT
2
HURTS
LITTLE MORE
3
HURTS
EVEN MORE
4
HURTS
WHOLE LOT
5
HURTS
WORST