Physical Therapy & Beyond

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Diagnostic Testing Screening Tool

Patient Name: ____ **Date:**_____________________

This screening tool can help your Therapist determine what diagnostic test(s) might be appropriate for you.

Please check off any of the following symptoms that you may have had within the past month or if you have any of these diagnosed conditions.

Check All that Apply:

Low Back Pain and Radiating Pain into Legs	
Neck Pain and Radiating Pain into Legs	
Numbness, Tingling or Burning Sensation in Legs	
Numbness, Tingling or Burning Sensation in Arms	
Weakness in Legs	
Weakness in Arms	
Diabetes	
Loss of Sensation in Hands	
Muscle Disease	
Dizziness or Vertigo	
Muscle Cramping	
Tendonitis	
Arthritis	
Joint pain	
Joint Instability	
Headaches	
Unsteady Gait	
History of Falls Due to Dizziness	
Thyroid Dysfunction	
Blurred Vision	
Hypertension or Hypotension	

Have you had any test performed for any of the checked conditions? ( ) Yes ( ) No

If yes, type of test & date test was completed: ____

Patient Signature: ____

OFFICE USE ONLY

PT Initials**:** __________

Insurance Plan: _____________________________________ Diagnosis: ____

Test to be Scheduled: ________ Date Test Scheduled: ____________________ Location: _________________________