PELTZ AND ASSOCIATES
PHYSICAL THERAPY INC

MEDICAL SCREENING FORM

Head and Neck Pain

REASON FOR VISIT

Nature of your illness/injury:_____

Date of Onset/Surgical Date:_____

MAJOR ILLNESS/SURGICAL HISTORY

Date:_____	Type:_____
Date:_____	Type:_____
Date:_____	Type:_____

MEDICAL HISTORY

Do you have, or have you had any of the following:

☐ Yes ☐ No Heart Problems
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Rheumatoid Arthritis
☐ Yes ☐ No Mental Health Condition
☐ Yes ☐ No Women: Are you pregnant or think you may become pregnant?
☐ Yes ☐ No Depression
☐ Yes ☐ No Epilepsy/Seizures
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Polio
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Allergies
☐ Yes ☐ No Cancer

Details/Other:_____

_____

SPECIAL SCREENING QUESTIONS FOR HEAD AND NECK PAIN

☐ Yes ☐ No Have you recently had difficulty speaking?
☐ Yes ☐ No Have you noticed an increased clumsiness or weakness in your arms or legs?
☐ Yes ☐ No Do you frequently have headaches?
☐ Yes ☐ No Have you noticed a recent decreased ability to concentrate?
☐ Yes ☐ No Do you experience dizziness?
☐ Yes ☐ No Have you noticed a recent change in your vision or ability to see?
☐ Yes ☐ No Have you recently experienced a blow to your head or a whiplash injury?
☐ Yes ☐ No Have you been experiencing nausea and/or vomiting?
☐ Yes ☐ No Do you currently have a fever, or have you had a fever recently?
☐ Yes ☐ No Have you recently been living in close quarters, such as a dormitory?
☐ Yes ☐ No Do you have a depressed immune system?
☐ Yes ☐ No Are your eyes sensitive to light?
☐ Yes ☐ No Have you recently had a seizure?
☐ Yes ☐ No Do you have a pacemaker?

CURRENT MEDICATIONS

Please list:_____

_____

PLEASE PRINT YOUR NAME BELOW

Printed Name:_____Date:_____