PELTZ AND ASSOCIATES
PHYSICAL THERAPY INC

MEDICAL SCREENING FORM

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

Details/Other:_____

_____

SPECIAL SCREENING QUESTIONS FOR LOW BACK PAIN

☐ Yes ☐ No Have you recently had a major trauma, such as a vehicle accident or a fall from a height?
☐ Yes ☐ No Have you ever had a medical practitioner tell you that you have osteoporosis?
☐ Yes ☐ No Do you have a history of cancer?
☐ Yes ☐ No Does your pain ease when you rest in a comfortable position?
☐ Yes ☐ No Have you recently had a fever?
☐ Yes ☐ No Have you recently lost weight without attempting to eat less or exercise more?
☐ Yes ☐ No Have you recently taken antibiotics or other medications for infection?
☐ Yes ☐ No Are you currently taking steroids or have you been on prolonged steroid therapy?
☐ Yes ☐ No Have you been diagnosed with an immunosuppressive disorder?
☐ Yes ☐ No Have you noticed a recent onset of difficulty retaining your urine?
☐ Yes ☐ No Have you noticed a recent need to urinate more frequently?
☐ Yes ☐ No Have you noticed a recent onset of numbness anywhere on your bottom or genitals?
☐ Yes ☐ No Have you recently noticed your legs becoming weak while walking or climbing stairs?

CURRENT MEDICATIONS

Please list:_____

_____

PLEASE PRINT YOUR NAME BELOW

Printed Name:_____Date:_____