



PELTZ AND ASSOCIATES  
PHYSICAL THERAPY INC

MEDICAL SCREENING FORM

Multiple Body Area Pain/Other

**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:

- |                                                                                                                    |                                                                            |                                                                    |
|--------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Problems                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No Depression        | <input type="checkbox"/> Yes <input type="checkbox"/> No Polio     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis      | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Health Condition                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis         | <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Women: Are you pregnant or think you may become pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer            |                                                                    |

Details/Other: \_\_\_\_\_

**MULTIPLE BODY AREA PAIN/OTHER SCREENING QUESTIONS**

- Yes  No Have you recently experienced a blow to the head or a whiplash type injury?
- Yes  No Have you recently experienced a trauma, such as a vehicle accident, a fall, or a sports injury?
- Yes  No Have you recently sustained a blow to your shin or any other trauma to either of your legs?
- Yes  No Have you recently begun a vigorous physical training program?
- Yes  No Are you currently taking steroids or have you been on prolonged steroid therapy?
- Yes  No Have you ever had a medical practitioner tell you that you have osteoporosis?
- Yes  No Have you noticed any recent weakness, tingling, or numbness in your arms or legs?
- Yes  No Do you have groin or thigh pain that increases when you cough or sneeze?
- Yes  No Have you noticed a recent onset of difficulty retaining your urine?
- 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?
- Yes  No Do you have groin, hip, thigh or calf aching or pain that increases with physical activity?
- Yes  No Have you recently taken a long car ride, bus trip, or plane flight?
- Yes  No Have you recently been bedridden?
- Yes  No Has a member of your immediate family (parent/sibling) ever been diagnosed with cancer?
- Yes  No Have you recently lost weight without attempting to eat less or exercise more?
- Yes  No Does your pain ease when you rest in a comfortable position?
- Yes  No Have you noticed a recent need to urinate more frequently?
- Yes  No Do you smoke or have you been a smoker in the past?
- Yes  No Have you noticed any newly formed or irregular moles on your body?



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- Yes  No Have you noticed a new onset of headache that is getting progressively worse?
- Yes  No Have you had a recent change in your bowel function (i.e. Black stools/Rectal bleeding)?
- Yes  No Do you feel sick to your stomach to the point where you feel like vomiting?
- Yes  No Have you recently had a fever, infection, or illness?
- Yes  No Have you recently taken antibiotics or other medications for infection?
- Yes  No Have you recently had a sore, cut, scrape, wound, or human/animal bite?
- Yes  No Do you administer medications or drugs to yourself for which you need to use a needle?
- Yes  No Have you had a recent surgery?
- Yes  No Have you had a recent injection to one or more of your joints?
- Yes  No Have you had diarrhea or constipation that has lasted for more than a few days?
- Yes  No In the past few weeks, have you noticed that when you cough, you easily cough up sputum?
- Yes  No Have you recently been living in close quarters, such as a dormitory?
- Yes  No Are your eyes sensitive to light?
- Yes  No Have you recently had a seizure?
- Yes  No Do you frequently have headaches?
- Yes  No Have you noticed a recent decreased ability to concentrate?
- Yes  No Have you recently had difficulty speaking?
- Yes  No Have you noticed a recent change in your vision or ability to see?
- Yes  No Do you take medication for hypertension?
- Yes  No Have you recently taken a nitroglycerine tablet?
- Yes  No Do you have a pacemaker?
- Yes  No Have you been diagnosed with an immunosuppressive disorder?
- Yes  No Have you noticed an inability to move your wrist or elbow normally?
- Yes  No Do you hands or feet easily turn white or become painful when cold?
- Yes  No When you have pain, does it respond to pain medication?
- Yes  No Have you recently noticed that it is difficult for you to breathe, laugh, sneeze or cough?
- Yes  No Do you experience dizziness?
- Yes  No Have you ever had a physician tell you that you have blood circulation problems in your hips?
- Yes  No If female, have you recently experienced increased pain during your menstrual period?

**CURRENT MEDICATIONS**

Please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE PRINT YOUR NAME BELOW**

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_