



PELTZ AND ASSOCIATES  
PHYSICAL THERAPY INC

MEDICAL SCREENING FORM

Neck or Shoulder 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:

- |  |  |  |
|--|--|--|
| <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: \_\_\_\_\_  
\_\_\_\_\_

**SPECIAL SCREENING QUESTIONS FOR NECK AND SHOULDER PAIN**

- Yes  No Have you recently experienced a blow to the head or a whiplash type injury?
- Yes  No Are you currently taking steroids or have you been on prolonged steroid therapy?
- Yes  No Have you noticed any recent weakness, tingling, or numbness in your arms or legs?
- Yes  No Have you noticed a recent onset of difficulty retaining your urine?
- Yes  No Do you now smoke or have you been a smoker in the past?
- Yes  No Do you administer medications or drugs to yourself for which you need to use a needle?

**CURRENT MEDICATIONS**

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

**PLEASE PRINT YOUR NAME BELOW**

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