PELTZ AND ASSOCIATES
PHYSICAL THERAPY INC

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?
☐ 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 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 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 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 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 If female, have you recently experienced increased pain during your menstrual period?

PELTZ AND ASSOCIATES
PHYSICAL THERAPY INC

Please answer a few more questions about your health.

1. Please enter your height and weight. Height: _____ft_____inches
   Weight:_____lbs
2. Over the last two weeks, how often have you been bothered by: Little interest or pleasure in doing things?
   a. Not at all b. Several days c. More than half the days d. Nearly every day

3. Over the last two weeks, how often have you been bothered by: Feeling down, depressed or hopeless?
   a. Not at all b. Several days c. More than half the days d. Nearly every day

4. Next we are going to ask you to describe 3 activities you are having difficulty with due to your current problem. This will help your Physical Therapist understand your limitations in a more personalized way. After typing/writing in your activity, please rate it on a scale of 0 (unable to perform) to 10 (able to perform without difficulty).
   a. Activity #1: _____
   Score for Activity #1 (please circle/highlight): 0 1 2 3 4 5 6 7 8 9 10

   b. Activity #2: _____
   Score for Activity #2 (please circle/highlight): 0 1 2 3 4 5 6 7 8 9 10

   c. Activity #2: _____
   Score for Activity #2 (please circle/highlight): 0 1 2 3 4 5 6 7 8 9 10

PLEASE PRINT YOUR NAME BELOW

Printed Name:_____Date:_____

PELTZ AND ASSOCIATES
PHYSICAL THERAPY INC

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 Cancer

Details/Other:_____

_____