PELTZ AND ASSOCIATES
PHYSICAL THERAPY INC

MEDICAL SCREENING FORM

Chest, Rib, or Mid-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 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 CHEST, RIB, OR MID-BACK PAIN

☐ Yes ☐ No Have you recently taken a nitroglycerine tablet?
☐ Yes ☐ No Do you take medication for hypertension?
☐ Yes ☐ No Have you been or are you now a smoker?
☐ Yes ☐ No Does your pain ease when you rest in a comfortable position?
☐ Yes ☐ No Have you recently had a major trauma, such as a motor vehicle accident or a fall?
☐ Yes ☐ No Have you ever had a medical practitioner tell you that you have osteoporosis?
☐ Yes ☐ No Have you had a recent surgery?
☐ Yes ☐ No Have you recently been bedridden?
☐ Yes ☐ No Have you recently noticed that it is difficult for you to breathe, laugh, sneeze or cough?
☐ Yes ☐ No Have you recently had a fever, infection, or illness?
☐ Yes ☐ No In the past few weeks, have you noticed that when you cough, you easily cough up sputum?

CURRENT MEDICATIONS

Please list:_____

_____

_____

PLEASE PRINT YOUR NAME BELOW

Printed Name:_____Date:_____