PELTZ AND ASSOCIATES
PHYSICAL THERAPY INC

MEDICAL SCREENING FORM

Knee, Leg, Ankle, or Foot 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 KNEE, LEG, ANKLE, OR FOOT PAIN

☐ Yes ☐ No Have you recently experienced a trauma, such as a vehicle accident, a fall, or a sports injury?
☐ Yes ☐ No Have you recently had a fever?
☐ Yes ☐ No Have you recently taken antibiotics or other medications for an infection?
☐ 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 recently had a cut, scrape, or open wound?
☐ Yes ☐ No Do you have a history of cancer?
☐ Yes ☐ No Have you recently taken a long car ride, bus trip, or plane flight?
☐ Yes ☐ No Have you recently been bedridden for any reason?
☐ Yes ☐ No Have you recently begun a vigorous physical training program?
☐ Yes ☐ No Do you have groin, hip, thigh or calf aching or pain that increases with physical activity?
☐ Yes ☐ No Have you recently sustained a blow to your shin or any other trauma to either of your legs?

PLEASE PRINT YOUR NAME BELOW

Printed Name:_____ Date:_____