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:

☐ 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 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?

PLEASE PRINT YOUR NAME BELOW

Printed Name:_____ Date:_____