



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:

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