



PELTZ AND ASSOCIATES
PHYSICAL THERAPY INC

MEDICAL SCREENING FORM

Head and Neck 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 HEAD AND NECK PAIN

- Yes No Have you recently had difficulty speaking?
- Yes No Have you noticed an increased clumsiness or weakness in your arms or legs?
- Yes No Do you frequently have headaches?
- Yes No Have you noticed a recent decreased ability to concentrate?
- Yes No Do you experience dizziness?
- Yes No Have you noticed a recent change in your vision or ability to see?
- Yes No Have you recently experienced a blow to your head or a whiplash injury?
- Yes No Have you been experiencing nausea and/or vomiting?
- Yes No Do you currently have a fever, or have you had a fever recently?
- Yes No Have you recently been living in close quarters, such as a dormitory?
- Yes No Do you have a depressed immune system?
- Yes No Are your eyes sensitive to light?
- Yes No Have you recently had a seizure?
- Yes No Do you have a pacemaker?

CURRENT MEDICATIONS

Please list: _____

PLEASE PRINT YOUR NAME BELOW

Printed Name: _____ Date: _____