CUSTOM PHYSICAL THERAPY

"Fit To Your Needs"

Patient Questionnaire

Patient's Name: _____ Age: _____ Date: _____

Date Of Injury/Surgery: _____

1. Do you now have/or have you ever had any of the following:

	YES	NO		YES	NO
Diabetes			Sensitive to Heat/Ice		
High Blood Pressure			Pregnant (Currently)		
Heart Disease			Allergies		
Heart Attack			Previous Surgery		
Pacemaker			Hernia (Ventral, Inguinal, etc.)		
Headaches			Seizures		
Kidney Problems			Metal Implants		
Nervous Disorders			Cancer		
Asthma			Bladder/Bowel Control		
Heart Burn			Ulcers		
Prostate					

If YES on any of the above, please explain and give approximate dates:

_____

_____

_____

2. Are you presently taking medication? YES_____ NO_____

Medication	Dosage	For What Condition

3. Do you need assistance with any of the following (circle):

Transportation	Yes	No	Meals	Yes	No
Shopping/Errands	Yes	No	Personal Care	Yes	No
Domestic Chores	Yes	No	Other_____		

4. Has your illness/disability caused any of the following (circle):

Financial Problems	Yes	No	Family Problems	Yes	No
Emotional Problems	Yes	No	Other_____		

5. Do you have other problems or concerns that we should be made aware of?

_____

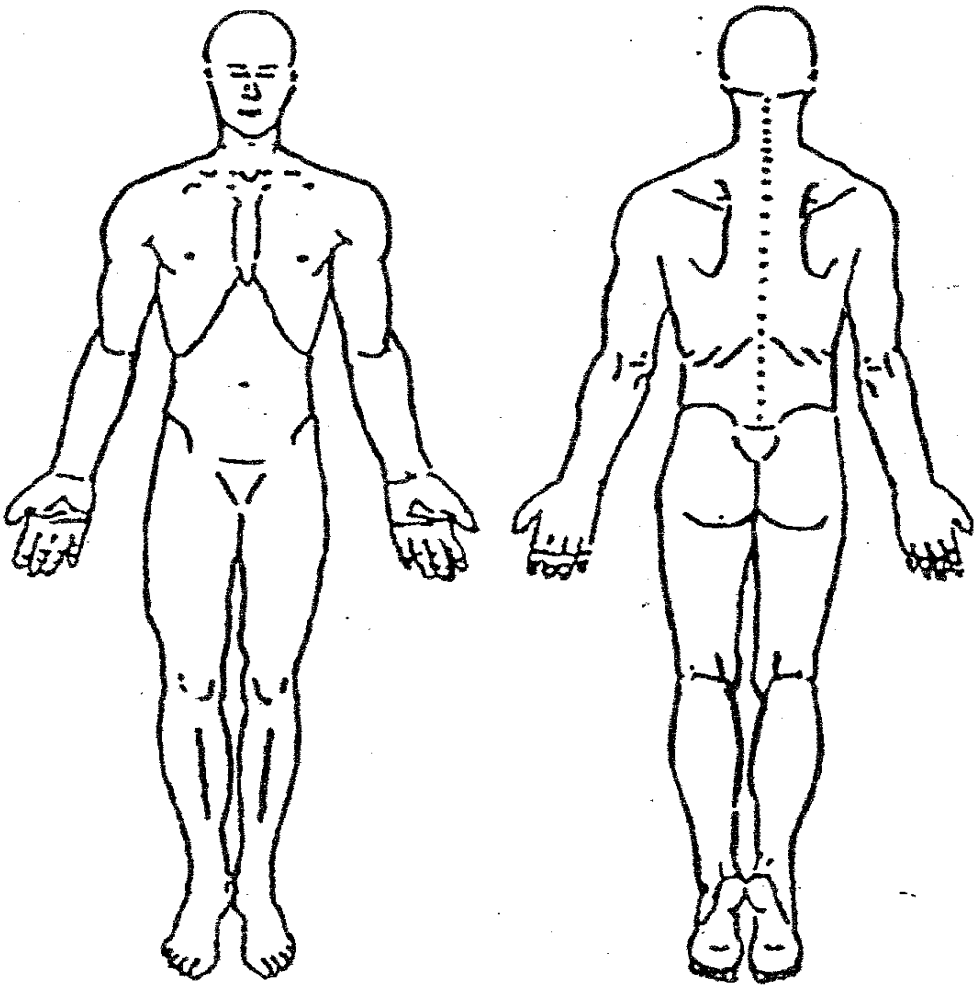
_____

(over)

6. Reason for Physical Therapy?

7. Describe your symptoms and /or complaints:

8. Please shade in areas of concern on the diagrams:



9. In case of an emergency, please notify:

Name: _____ Phone Number: ( ) _____

Relationship: _____

Patient Signature: _____ Date: _____