

NORTH SALINAS PHYSICAL THERAPY

Name: _____ Date: _____

The following questionnaire will assist the physical or occupational therapist in thoroughly evaluating your present needs and condition. Most of the questions require a check mark or short answer. Please take the time to answer the questions to the best of your ability.

CURRENT MEDICAL HISTORY:

List any medical conditions for which you are currently being treated by a physician:

1. _____ 2. _____
3. _____ 4. _____

Are you pregnant? Yes No

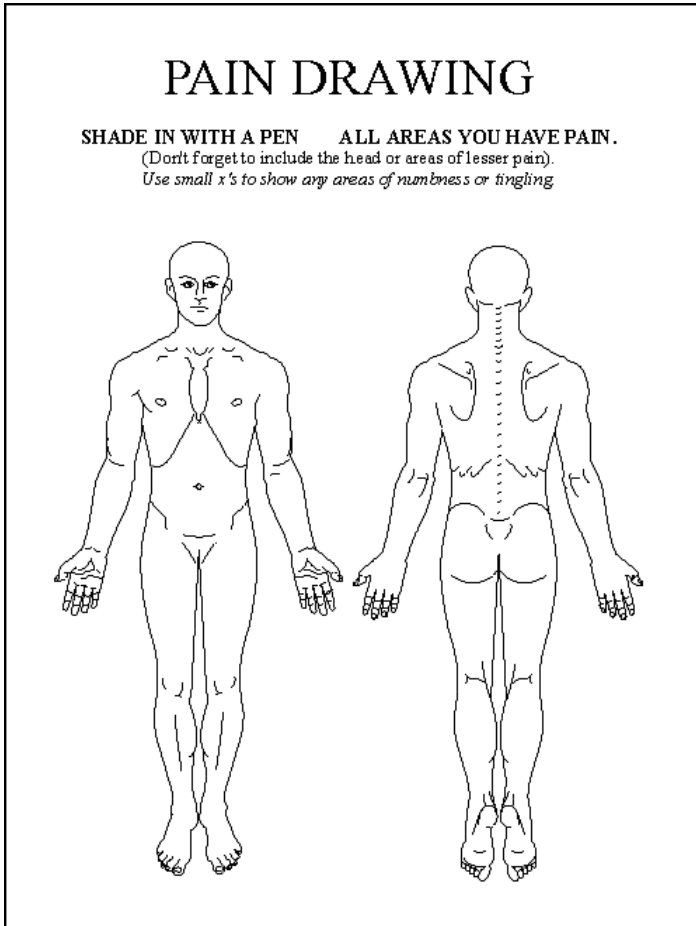
Are you taking any medications? Yes No If yes, list them:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

ALLERGIES: _____

Do you difficulty breathing during exercise? Yes No

Indicate on the picture below, where you are experiencing pain at this time:



CHECK ANY CONDITIONS APPLICABLE & THE YEAR FIRST TREATED:

<u>Condition</u>	<u>Year</u>	<u>Condition</u>	<u>Year</u>
<input type="checkbox"/> Bone Fracture	_____	<input type="checkbox"/> Disc Disease	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Joint Pain	_____
<input type="checkbox"/> Heart Attack	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Numbness	_____	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Bleeding	_____	<input type="checkbox"/> Easy Bruising	_____
<input type="checkbox"/> Shortness of Breath	_____	<input type="checkbox"/> Dizziness	_____
<input type="checkbox"/> Metal or other Implants	_____	<input type="checkbox"/> Pacemaker	_____
<input type="checkbox"/> Dermatitis	_____	<input type="checkbox"/> Kidney Disorders	_____
<input type="checkbox"/> Spine Disease	_____	<input type="checkbox"/> Gout	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Paralysis	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Headaches	_____	<input type="checkbox"/> Circulation Problems	_____
<input type="checkbox"/> Hernia	_____		
<input type="checkbox"/> Surgery – Type: _____			
<input type="checkbox"/> Cancer of _____			

Do you exercise regularly? Yes No If yes, how often? _____ timer per week or _____ times per month.

What type of exercise: _____

Are you disabled? Yes No

Do you smoke? Yes No How many packs per day? _____

Do you drink alcohol? Yes No How often? _____

Any additional information: _____
