reCOOPERation
PHYSICAL THERAPY
SYMMETRY IN BALANCE AND MOTION

## *PATIENT QUESTIONNAIRE*

**Patient's Name**_____ **Age**_____ **Date**_____

### MEDICAL HISTORY

**Do you now have/or had any of the following:**

| | | | |
|---|---|---|---|
| **High Blood Pressure** | **Yes**_____ **No**_____ | **Asthma** | **Yes**_____ **No**_____ |
| **Heart Disease** | **Yes**_____ **No**_____ | **Sensitive to heat/ice** | **Yes**_____ **No**_____ |
| **Heart Attack** | **Yes**_____ **No**_____ | **Allergies** | **Yes**_____ **No**_____ |
| **Diabetes** | **Yes**_____ **No**_____ | **Hernia** | **Yes**_____ **No**_____ |
| **Pacemaker** | **Yes**_____ **No**_____ | **Headaches** | **Yes**_____ **No**_____ |
| **Cancer** | **Yes**_____ **No**_____ | **Kidney problems** | **Yes**_____ **No**_____ |
| **Metal Implants** | **Yes**_____ **No**_____ | **Nervous Disorders** | **Yes**_____ **No**_____ |
| **Pregnant (currently)** | **Yes**_____ **No**_____ | **Seizures** | **Yes**_____ **No**_____ |
| **Previous surgeries** | **Yes**_____ **No**_____ | | |

**If Yes on any of the above, please explain and give approximate dates:**_____

_____

_____

**Are you presently taking medication? Yes**____ **No** ____

**If yes, what medication and for what condition?**_____

_____

_____

**Reason for Physical Therapy (include dates and circumstances):**_____

_____

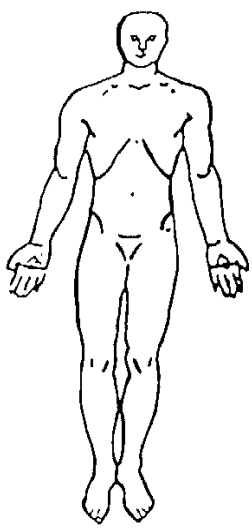
_____

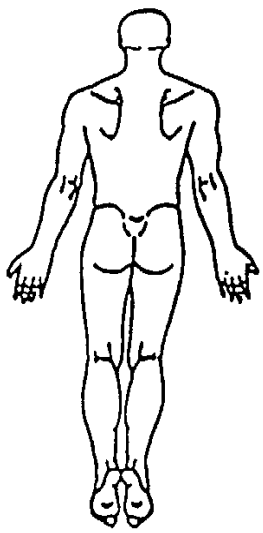
_____

**Do you have problems or concerns we should be made aware of?**_____

_____

Please shade in areas of concern on the diagrams below:





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Patient Signature