SOARING eagle PHYSICAL THERAPY, PC

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Medical History Questionnaire

Name:_____Today's Date:_____

Physician's Name:_____Area of Speciality:_____

PAST MEDICAL HISTORY:

Have you *ever* had:

___Yes___No Rheumatic Fever
___Yes___No Heart Murmer
___Yes___No High blood pressure
___Yes___No Angina or chest pain
___Yes___No Heart Attack
___Yes___No Abnormal EKG
___Yes___No Other heart trouble
___Yes___No Diabetes
___Yes___No Arthritis
___Yes___No Disease of the arteries
___Yes___No Varicose veins
___Yes___No Asthma
___Yes___No Lung disease
___Yes___No Back injury
___Yes___No Epilepsy
___Yes___No Gout
___Yes___No Surgeries

Have you *recently* had:

___Yes___No Chest Pain
___Yes___No Shortness of Breath
___Yes___No Dizziness, faintness, or loss of consciousness
___Yes___No Heart palpitations
___Yes___No Cough on exertion
___Yes___No Kidney problems
___Yes___No High cholestrol
___Yes___No High blood pressure
___Yes___No Breathlessness at rest
___Yes___No Coughing up blood
___Yes___No Disability of feet, ankles, knees, hips, and/or neck
___Yes___No Swollen and stiff painful joints

If you checked any of the above, please explain:_____
_____
_____
_____
_____
_____

Do you have any medical problems that would limit your ability to exercise?
___Yes___No
If yes, please explain:_____
_____
_____

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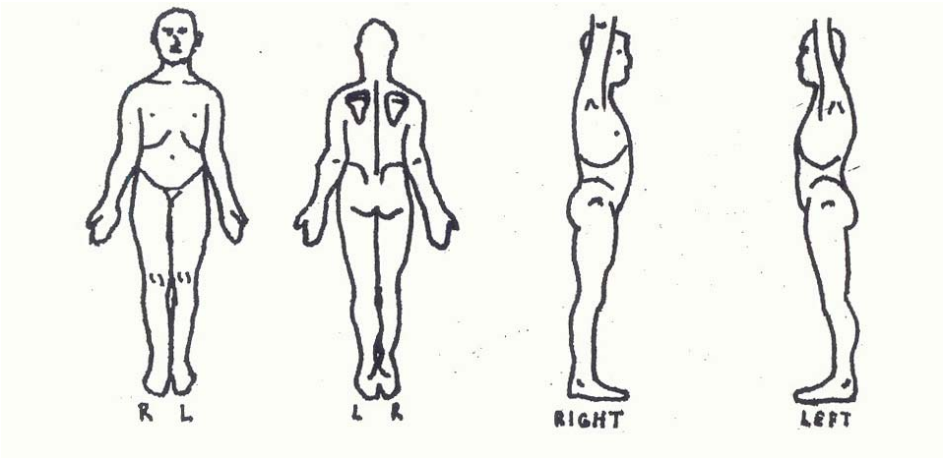
PATIENT HISTORY (SELF REPORT)



Where are your symptoms located? (Darken areas on body above)

1. When did your symptoms begin?_____

2. Circle the words that best describe your symptoms: aching, burning, tingling, stabbing, throbbing, numbness

3. Are your symptoms due to an accident or trauma? (Describe)
   _____
   _____
   _____

4. What makes you feel better?_____

5. What makes you feel worse?_____

6. Please list any relevant medical history/medications and dosages:
_____

7. Please list any diagnostic test results (X-rays, MRI, CT Scan, Myelogram, etc.):
_____

8. Please list any interventions prior to physical therapy (injections, splints, medications, etc.):_____