PHYSICAL THERAPY

Significant Medical History Questionnaire

Please circle any disorder you have been diagnosed with in order to prevent exacerbation of the condition. (All information is given is medically confidential).

1. Cancer Tumors
2. Cardiac condition
3. Pacemaker implant
4. High Blood Pressure
5. Blood Clots
6. Asthama or breathing disorder
7. Osteoporosis
8. Diabetis
9. Osteoarthiritis
10. Acute Inflammatory Diseases
11. Dizziness, Double vision, Fainting attacks, Difficuties with Speech, Swallowing or Talking
12. Hepatitis A/B/C
13. Bowel/Bladder condition
14. Unexpected weight loss
15. Skin Disorder
16. Sensation changes in extremities
17. Metal in Body (Pins, Screws, Plates)
18. Possible Pregnancy
19. Neck
20. Neck
21. Mid and/or Lower Back
22. Hip
23. Knee
24. Ankle

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Moderate Severe Very Severe Worst Pain Possible

Medications:_____

If any of the above conditions are circled, please explain briefly including date and indicating number _____

_____

_____

The above information is true to the best of my knowledge

Signature _____ Date_____

ACTION MOTION PERFORMANCE

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