

**PATIENT HISTORY QUESTIONNAIRE**

PLEASE FILL OUT THIS COFIDENTIAL FORM AS COMPLETELY AS POSSIBLE. IT WILL ASSIST YOUR THERAPIST IN DEVELOPING A PLAN OF CARE FOR YOU. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK FOR ASSISTANCE.

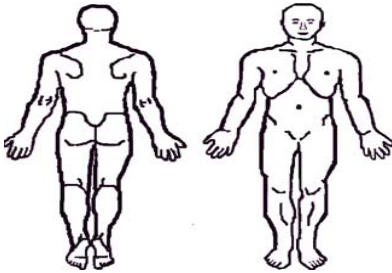
NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ HOBBIES \_\_\_\_\_

WHERE IS THE AREA OF INJURY? \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_

HOW DID THE INJURY OCCUR? \_\_\_\_\_

INDICATE WHERE YOU HAVE PAIN/SYMPOMS:



PLEASE CIRCLE: SUDDEN ONSET GRADUAL ONSET  
 HAS THIS INJURY PREVENTED YOU FROM WORKING? YES NO  
 \_\_\_\_\_ IF YES, HOW LONG?  
 HAVE YOU SOUGHT PREVIOUS TREATMENT, OR ARE YOU CURRENTLY RECEIVING OTHER CARE FOR THIS CONDITION?  
 \_\_\_\_\_ NO OTHER TREATMENT \_\_\_\_\_ MASSAGE THERAPY  
 \_\_\_\_\_ CHIROPRACTOR \_\_\_\_\_ PHYSICAL/OCCUPATIONAL THEARPY  
 \_\_\_\_\_ PSYCHIATRIST/PSYCHOLOGIST \_\_\_\_\_ OTHER

LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING (IF YOU HAVE A LIST WITH YOU, WE CAN MAKE A COPY).

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PLEASE LIST PAST SURGERIES, AS WELL AS MEDICAL CONDITIONS THAT YOU HAVE OR ARE BEING TREATED FOR.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

ALLERGIES (INCLUDING LATEX) \_\_\_\_\_

DO YOU HAVE A PACEMAKER? YES NO

ARE YOU CURRENTLY EXPERIENCING OR HAVE YOU EXPERIENCED ANY OF THESE SYMPTOMS IN THE PAST 3 MONTHS?

\_\_\_\_\_ FEVER \_\_\_\_\_ CHILLS \_\_\_\_\_ NIGHT SWEATS \_\_\_\_\_ SHORTNESS OF BREATH

\_\_\_\_\_ NUMBNESS \_\_\_\_\_ HEADACHES \_\_\_\_\_ VISION PROBLEMS \_\_\_\_\_ HEARING LOSS

\_\_\_\_\_ BOWEL OR BLADDER DYSFUNCTION \_\_\_\_\_ EXCESSIVE WEIGHT GAIN/LOSS \_\_\_\_\_ PREGNANT

RATE YOUR PAIN ON A SCALE FROM 0-10, 0 BEING NO PAIN AND 10 BEING THE WORST POSSIBLE PAIN. \_\_\_\_\_

\_\_\_\_\_  
 PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
 DATE