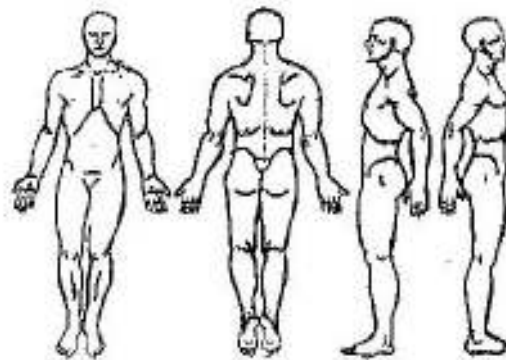
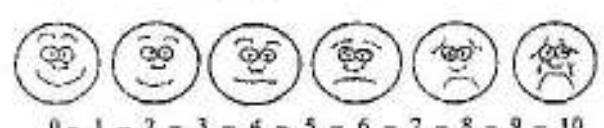


Please complete the following questionnaire to assist your PT or ATC in developing the most appropriate rehabilitation program for you. *Thank you!*

<p style="text-align: center;"><u>Medical / Surgical History</u></p> <p>Please check all that apply:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Arthritis <input type="checkbox"/> Broken bones/fracture <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Blood Disorders <input type="checkbox"/> Circulation/Vascular problems <input type="checkbox"/> Heart Problems <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Lung problems <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Head Injury <input type="checkbox"/> Depression <input type="checkbox"/> High Cholesterol </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Parkinson Disease <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Developmental or growth problems <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Cancer <input type="checkbox"/> Infectious disease <input type="checkbox"/> Kidney problems <input type="checkbox"/> Repeated infection <input type="checkbox"/> Ulcers/Stomach problems <input type="checkbox"/> Skin diseases <input type="checkbox"/> Presently pregnant </td> </tr> </table> <p><input type="checkbox"/> Other: _____</p> <p>Within the past year, have you had any of the following symptoms?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Cough <input type="checkbox"/> Hoarseness <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Dizziness or blackouts <input type="checkbox"/> Coordination problems <input type="checkbox"/> Weakness in arms or legs <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Balance difficulties </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Bowel problems <input type="checkbox"/> Weight loss/gain <input type="checkbox"/> Urinary problems <input type="checkbox"/> Fever/chills/sweats <input type="checkbox"/> Headaches <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Uncorrected Vision problems </td> </tr> </table> <p><input type="checkbox"/> Have you fallen within the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> other concern: _____</p> <p style="text-align: center;"><u>Current Daily Activities</u> (check & list all that apply)</p> <p><input type="checkbox"/> Housework <input type="checkbox"/> Yard Work</p> <p><input type="checkbox"/> Hobbies _____</p> <p><input type="checkbox"/> Employment _____</p> <p><input type="checkbox"/> Sports _____</p> <p><input type="checkbox"/> Exercise (describe frequency/duration/program/location) _____</p>	<input type="checkbox"/> Arthritis <input type="checkbox"/> Broken bones/fracture <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Blood Disorders <input type="checkbox"/> Circulation/Vascular problems <input type="checkbox"/> Heart Problems <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Lung problems <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Head Injury <input type="checkbox"/> Depression <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Parkinson Disease <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Developmental or growth problems <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Cancer <input type="checkbox"/> Infectious disease <input type="checkbox"/> Kidney problems <input type="checkbox"/> Repeated infection <input type="checkbox"/> Ulcers/Stomach problems <input type="checkbox"/> Skin diseases <input type="checkbox"/> Presently pregnant	<input type="checkbox"/> Chest pain <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Cough <input type="checkbox"/> Hoarseness <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Dizziness or blackouts <input type="checkbox"/> Coordination problems <input type="checkbox"/> Weakness in arms or legs <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Balance difficulties	<input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Bowel problems <input type="checkbox"/> Weight loss/gain <input type="checkbox"/> Urinary problems <input type="checkbox"/> Fever/chills/sweats <input type="checkbox"/> Headaches <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Uncorrected Vision problems	<p style="text-align: center;"><u>Current Conditions / Chief Complaint(s)</u></p> <p>Describe the problem(s) for which you seek therapy:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>When did problem(s) begin? Month ___ Day ___ Year ___ Injury / other cause? _____</p> <p>What makes the problem worse? _____</p> <p>What makes the problem better? _____</p> <p>What are your goals for therapy? _____</p> <p>_____</p> <p>Are you on any Medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list medications: _____</p> <p>_____</p> <p style="text-align: center;"><u>Pain:</u></p> <p>Do you have pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain location: please shade in the area of your pain</p> <div style="text-align: center;">  </div> <p style="text-align: center;"><i>Underline the range from the best you feel to the worst and Circle the present intensity</i></p> <div style="text-align: center;">  <p>0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10</p> </div> <p>Pain Quality: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Ache <input type="checkbox"/> Other: _____</p> <p>Pain Frequency: (check all that apply) <input type="checkbox"/> Less than daily <input type="checkbox"/> Daily episodes <input type="checkbox"/> Increases throughout day <input type="checkbox"/> Constant <input type="checkbox"/> Night Pain <input type="checkbox"/> Other: _____</p>
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