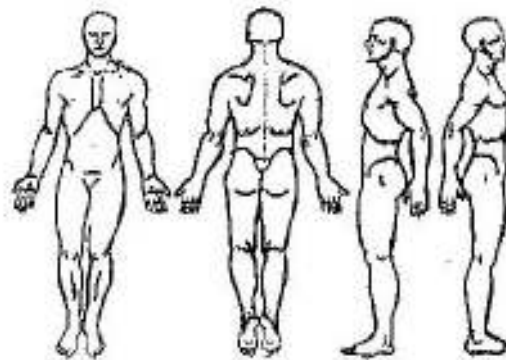
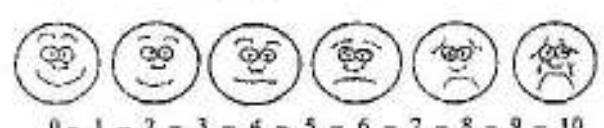


Please complete the following questionnaire to assist your PT or ATC in developing the most appropriate rehabilitation program for you. *Thank you!*

<p style="text-align: center;"><b><u>Medical / Surgical History</u></b></p> <p><b>Please check all that apply:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Arthritis</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Multiple Sclerosis</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Broken bones/fracture</td> <td style="border: none;"><input type="checkbox"/> Muscular dystrophy</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Osteoporosis</td> <td style="border: none;"><input type="checkbox"/> Parkinson Disease</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Blood Disorders</td> <td style="border: none;"><input type="checkbox"/> Seizures/Epilepsy</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Circulation/Vascular problems</td> <td style="border: none;"><input type="checkbox"/> Developmental or growth problems</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Heart Problems</td> <td style="border: none;"><input type="checkbox"/> Thyroid problems</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> High Blood Pressure</td> <td style="border: none;"><input type="checkbox"/> Cancer</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Lung problems</td> <td style="border: none;"><input type="checkbox"/> Infectious disease</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Stroke</td> <td style="border: none;"><input type="checkbox"/> Kidney problems</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Diabetes</td> <td style="border: none;"><input type="checkbox"/> Repeated infection</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Tuberculosis (TB)</td> <td style="border: none;"><input type="checkbox"/> Ulcers/Stomach problems</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Hypoglycemia</td> <td style="border: none;"><input type="checkbox"/> Skin diseases</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Head Injury</td> <td style="border: none;"><input type="checkbox"/> Presently pregnant</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Depression</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> High Cholesterol</td> <td style="border: none;"><input type="checkbox"/> Other: _____</td> </tr> </table> <p><b>Within the past year, have you had any of the following symptoms?</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Chest pain</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Difficulty sleeping</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Heart palpitations</td> <td style="border: none;"><input type="checkbox"/> Loss of appetite</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Cough</td> <td style="border: none;"><input type="checkbox"/> Nausea/vomiting</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Hoarseness</td> <td style="border: none;"><input type="checkbox"/> Difficulty swallowing</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Shortness of breath</td> <td style="border: none;"><input type="checkbox"/> Bowel problems</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Dizziness or blackouts</td> <td style="border: none;"><input type="checkbox"/> Weight loss/gain</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Coordination problems</td> <td style="border: none;"><input type="checkbox"/> Urinary problems</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Weakness in arms or legs</td> <td style="border: none;"><input type="checkbox"/> Fever/chills/sweats</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Hearing Problems</td> <td style="border: none;"><input type="checkbox"/> Headaches</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Joint Swelling</td> <td style="border: none;"><input type="checkbox"/> Difficulty walking</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Balance difficulties</td> <td style="border: none;"><input type="checkbox"/> Uncorrected Vision problems</td> </tr> </table> <p><input type="checkbox"/> <b>Have you fallen within the past year?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> other concern: _____</p> <p style="text-align: center;"><b><u>Current Daily Activities</u></b> (check &amp; 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"/> Multiple Sclerosis	<input type="checkbox"/> Broken bones/fracture	<input type="checkbox"/> Muscular dystrophy	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Parkinson Disease	<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Circulation/Vascular problems	<input type="checkbox"/> Developmental or growth problems	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Infectious disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Repeated infection	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Ulcers/Stomach problems	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Skin diseases	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Presently pregnant	<input type="checkbox"/> Depression		<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Cough	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Bowel problems	<input type="checkbox"/> Dizziness or blackouts	<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Coordination problems	<input type="checkbox"/> Urinary problems	<input type="checkbox"/> Weakness in arms or legs	<input type="checkbox"/> Fever/chills/sweats	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Headaches	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Balance difficulties	<input type="checkbox"/> Uncorrected Vision problems	<p style="text-align: center;"><b><u>Current Conditions / Chief Complaint(s)</u></b></p> <p>Describe the problem(s) for which you seek therapy:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>When did problem(s) begin?</b> 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><b>Are you on any Medications?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, list medications: _____</p> <p>_____</p> <p style="text-align: center;"><b><u>Pain:</u></b></p> <p><b>Do you have pain?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Pain location:</b> 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><b>Pain Quality:</b> <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><b>Pain Frequency:</b> (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>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Multiple Sclerosis																																																				
<input type="checkbox"/> Broken bones/fracture	<input type="checkbox"/> Muscular dystrophy																																																				
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Parkinson Disease																																																				
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Seizures/Epilepsy																																																				
<input type="checkbox"/> Circulation/Vascular problems	<input type="checkbox"/> Developmental or growth problems																																																				
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Thyroid problems																																																				
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer																																																				
<input type="checkbox"/> Lung problems	<input type="checkbox"/> Infectious disease																																																				
<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney problems																																																				
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Repeated infection																																																				
<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Ulcers/Stomach problems																																																				
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Skin diseases																																																				
<input type="checkbox"/> Head Injury	<input type="checkbox"/> Presently pregnant																																																				
<input type="checkbox"/> Depression																																																					
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Other: _____																																																				
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Difficulty sleeping																																																				
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Loss of appetite																																																				
<input type="checkbox"/> Cough	<input type="checkbox"/> Nausea/vomiting																																																				
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Difficulty swallowing																																																				
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Bowel problems																																																				
<input type="checkbox"/> Dizziness or blackouts	<input type="checkbox"/> Weight loss/gain																																																				
<input type="checkbox"/> Coordination problems	<input type="checkbox"/> Urinary problems																																																				
<input type="checkbox"/> Weakness in arms or legs	<input type="checkbox"/> Fever/chills/sweats																																																				
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Headaches																																																				
<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Difficulty walking																																																				
<input type="checkbox"/> Balance difficulties	<input type="checkbox"/> Uncorrected Vision problems																																																				