FYZICAL Therapy & Balance Centers MetroWest

Pre-Exam Health Questionnaire

1. Where is your pain/problem? _____

2. What caused your pain/problem? _____

3. Approximately how long ago did it start? _____

4. Is your pain/problem: *(circle all that apply)* Sharp Dull Ache Numb Shooting Tingling Burning

5. Is the pain getting: Much better Better Staying the same Worse Much worse

6. Have you ever had this pain/problem before? When? _____

7. On the scale, circle the worst your pain/problem has been in the past week.

8. What daily activities or hobbies have been affected by this problem? _____

9. Who have you seen before today for this condition? *(check all that apply)*
   - ☐ Medical Doctor
   - ☐ Acupuncturist
   - ☐ Chiropractor
   - ☐ Massage Therapist
   - ☐ Athletic/Personal Trainer
   - ☐ Occupational Therapist

10. Have you had physical therapy before? When? _____

11. List all surgeries you have had in the past 5 years. Please use the back of this sheet if you need more room. _____

12. Please list all medications you are taking, including dosage and frequency. Please use the back of this sheet if you need more room. _____

13. Please circle any condition you have or were told you have.

Abnormal Weight Gain/Loss	Cardiac Condition	Numbness	Stroke/TIAs: _____ (date)
Alcohol/Drug Dependency	Circulatory/Vascular Problems	Osteoporosis	Tobacco Use
Asthma	Diabetes	Pregnant: _____(weeks)	Seasonal/Pet Allergies
Arthritis	Epilepsy/Seizures	Psychiatric Conditions	Latex allergy
Cancer: _____ (site)	High Blood Pressure	Recent Unexplained Falls	Medication allergy: _____

Other allergies: _____ Other conditions: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone – HOME WORK CELL: _____ Phone – HOME WORK CELL: _____

The above is true and correct to the best of my knowledge.

Signature **Printed Name** **Date**