



PRE-EXAM QUESTIONNAIRE

Name:	Doctor:	Occupation:	Age:
Reason for coming to therapy:			
Date of Injury:	Date of Surgery:	Gender:	

PAST MEDICAL HISTORY

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Diabetes			Kidney problems			Thyroid Problems		
Arthritis			Pregnant			CVA/Stroke		
High blood pressure			Allergies			Previous Fracture		
Heart Disease			Seizures			Osteoporosis		
Pacemaker or surgical implant			Metal in Body			Respiratory Problems		
Headaches			Cancer/Tumor			Other:		

Any special tests completed for this injury? If so list the results:

MRI:	X-RAY:	CT SCAN:	EMG:
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MEDICATIONS:

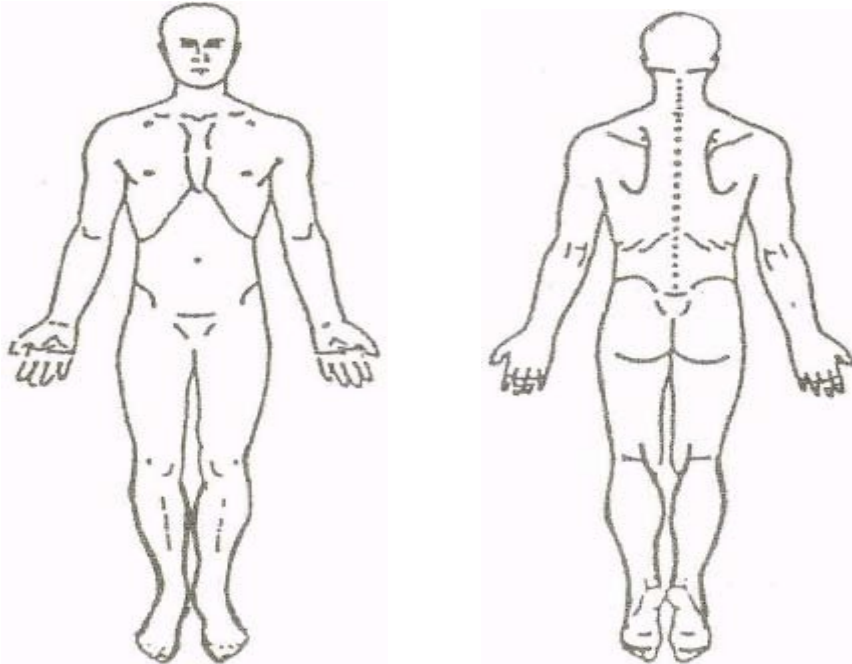
Prescription/Over the Counter/Vitamins	frequency	dosage

PAIN	YES	NO
Do you have Pain?		
Constant Pain?		
Night Pain?		
Numbness or Tingling?		

What activity increases your pain?

What eases your symptoms?

Please mark on the drawing where your pain is located:



PLEASE RATE YOUR PAIN ON A SCALE:

0---1---2---3---4---5---6---7---8---9---10

NO PAIN

WORST POSSIBLE PAIN

Patient/Guardian Signature: _____

Date: _____