Pre-Treatment Questionnaire

Name ______________________________________

Primary Care Physician ______________________________ Phone________________

Would you like a copy of your evaluation to be sent to your primary care physician? Y / N

Emergency Contact ____________________________ Phone___________________

Medical History:

1. Are you allergic to any medications? Y / N

   If yes, please list: ________________________ ___________________________

   ________________________ ___________________________

   ________________________ ___________________________

2. Are you currently taking any medication? Y / N

   If yes, please list: ________________________ ___________________________

   ________________________ ___________________________

   ________________________ ___________________________

3. Are you, or is there a possibility that you are pregnant? Y / N

4. Have you had any bone / joint surgeries? Y / N

   If yes, please list: ________________________ ___________________________

   ________________________ ___________________________

   ________________________ ___________________________

5. Have you ever had any adverse reactions to heat and/or cold? Y / N

6. Have you been diagnosed as having epilepsy, or other seizure disorder? Y / N

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7. Do you have any metal implants? Y / N
    If so, where?
8. Do you have any respiratory problems such as asthma, emphysema or COPD? Y / N
    If so, explain____________________________________
9. Do you have a heart condition? Y / N
    If so, explain____________________________________
10. Do you have an area of poor circulation? Y / N
    If so, explain____
11. Please list any further information not already discussed that we should be aware of prior to testing and/or treating your condition, ie. Cancer, diabetes, etc…

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12. Have you had any physical therapy in the past? Y / N
    If so, for what condition and when?

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I affirm that the information contained on this form is true and correct to the best of my knowledge. I also acknowledge that I have been offered a copy of Bardstown Rd. Physical Therapy Group, Inc.s notice of privacy practices and that I may request a copy at any time.

____ ________________________

Patient Signature Date