-PIONEER-
PHYSICAL THERAPY

108 N Township St. #F
Sedro-Woolley, WA 98284
PH: 360.854.9924
Fax: 360.854.9743

PRELIMINARY QUESTIONNAIRE

NAME: Sex: M / F Date of Birth:

Primary Physician: _____ Occupation:_____

MEDICATIONS:

Name/Type	Dosage

MEDICAL HISTORY: Do you have or have you ever had:
If your answer is **yes**, please mark the empty box with an **"X"** and explain below.

X		X	
	Back, disc problems, sciatic		*Heart disease
	HIV positive		*Congestive heart failure
	Tuberculosis or other lung disease		*Irregular heart beat
	Tumor or abnormal growth		*Heart surgery (angioplasty etc.)
	Asthma or other allergy		*Pressure or pain in chest, etc.
	Ulcers in stomach/intestines		*Swollen legs, ankles
	Disease of abdominal organs		*Breathlessness
	Communicable disease (specify)		*Stroke, vascular disease
	Arthritis		*Elevated blood pressure-note values
	Rheumatic fever – was heart affected?		*Epilepsy or other seizure disorders
	Kidney disease		*Nervous disorders
	Liver disease		*Gout
	General weakness		*Drug or alcohol abuse
	Frequent headaches		*Fainting episodes
	Vertigo		*Diabetes
	Thyroid or parathyroid disorders		Other prolonged/serious illness
	Nervousness, sleeplessness		Serious accident
	Disease of the eyes		Do you smoke?
	Disease of the ears		Osteoporosis
	Joint replacement		**If Female:**
	Anemia or other blood disorders		Breast cancer
	Hiatal hernia		*Currently pregnant
	Hepatitis		Disease of female organs
	Surgery		**If Male:**
	Cancer		Prostate problems
	Are you currently being treated for any illness **other** than the referred diagnosis?		

Comments: _____
_____

Have you had previous physical therapy for this condition? Yes_____ No_____
Have you been in physical therapy in the last year? Yes_____ No_____

I declare that all information in this preliminary questionnaire is true. If there are any changes in my medical history, I will notify Pioneer Physical Therapy.

Signature: _____Date:_____

Signature: _____Date:_____

Signature: _____Date:_____

Signature: _____Date:_____

Signature: _____Date:_____

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