Alternative Back Care
Physical Therapy *Achieving relief one back at a time*

INITIAL QUESTIONNAIRE

Name:	Date:
Insurance:	Date of Birth:
Physician:	Dx:
Next MD visit:	Date of injury:

Please list current medications: _____

Pertinent medical history? (prior surgeries, hospitalizations, etc.) _____

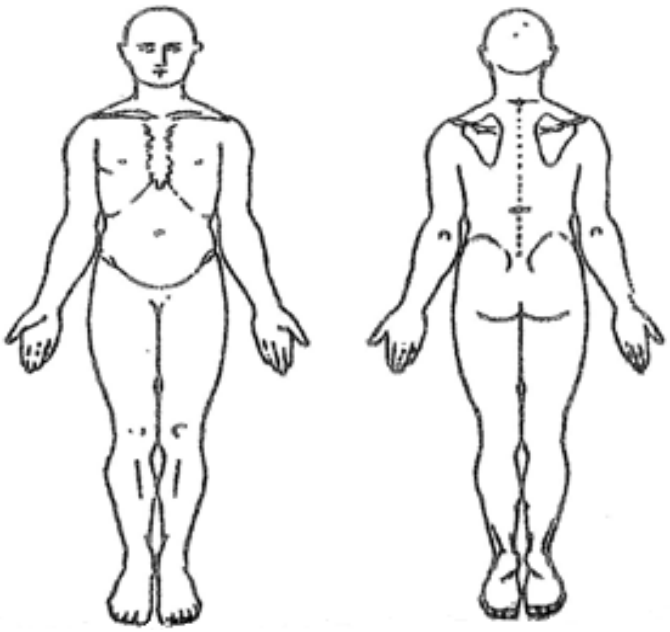
Please **X** if you have, or have had any of the following- use **other** below to elaborate:

Allergies		Osteoporosis		Possibly Pregnant	
Chest Pain		Arthritis		Broken Bones	
Heart Attack/Pacemaker		Joint replacement/pins		Dizziness	
Cancer		Asthma		Headache	
Diabetes		Lung Disease (below)		Back Pain	
High Blood Pressure		Hepatitis		Neck Pain	
Seizures		Sensitive to Chemicals		Numbness/Tingling	
Stroke		HIV+/Aids		Use of Tobacco	
Major Illness (below)		Epilepsy		Wear Orthotics	
Major Accident (below)		Tuberculosis		Bowel/ Bladder Trouble	

Other:_____

_____

On the chart below put **X**'s on areas of pain and **O**'s for numbness/ tingly areas.



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