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

# ***INITIAL QUESTIONNAIRE***

| | |
|---|---|
| Name: | Date: |
| Physician: | Dx: |
| Next MD visit: | Date of injury: |

How did you hear about us: _____

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.