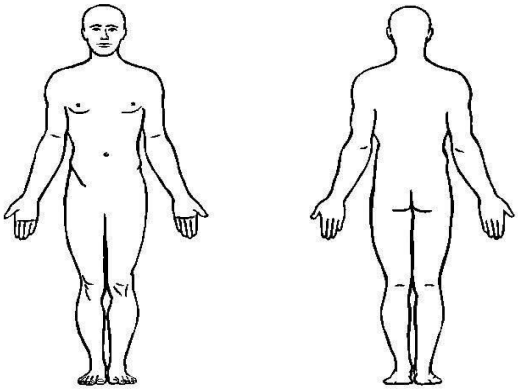
AERO PERFORMANCE + PHYSICAL THERAPY

Medical History Questionnaire

Name: _____ How did you hear about us: _____

Mark your symptoms on the figures



Pain (o) Numbness (x)
Tingling (~) Burning (^)
Weakness (#) Other (?)

If other, please explain: _____

_____

When did this start/Surgery Date:_____

How did this problem begin:_____

What factors do you think contributed to the onset of the problem:_____

_____

What makes your symptoms better: _____

What makes your symptoms worse: _____

Have you received Physical Therapy or Speech Therapy this year: Yes No
If yes, how many visits: _____

Have other Healthcare Professionals attempted to treat this same issue: Yes No
Who:_____ When:_____
What did they attempt:_____

What is your goal for therapy:_____

Medical History: Please include all information you feel is pertinent with surgery dates.

_____

Medications: (List here or provide a copy):_____

_____

Use back of page for anything else you think we should know