

AERO PERFORMANCE + PHYSICAL THERAPY

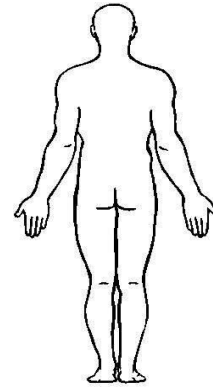
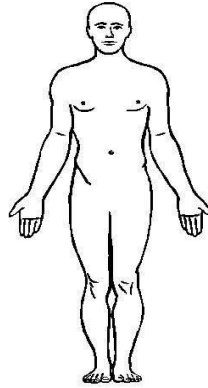
Medical History Questionnaire

Name: _____

How did you hear about us: _____

Mark your symptoms on the figures *(Please print to answer this section)*

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