

CASCADE SUMMIT PHYSICAL THERAPY

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Patient Questionnaire – Massage Therapy

Name _____ Today's Date _____

Date of Birth _____ Referring Physician _____

Date of Last Doctor's Visit: _____ Date of Next Doctor's Visit: _____

Other providers currently treating you: Physician (if different than referring physician) _____

Physical Therapist: Name: _____ Chiropractor: _____

Please list the following:

Any surgeries you have had: _____

Any accidents, injuries or chronic illnesses: _____

Medications you are now taking: _____

For women: Are you currently pregnant? Yes No Or recently delivered: Date _____

HISTORY OF CURRENT PROBLEM:

Date of injury or when did the problem begin? _____

Please describe what happened _____

Have you ever had the problem before? Yes No If yes, what did you do for the problem? _____

Did the problem get better? Yes No About how long did the problem last? _____

What activities are you having difficulty performing now that you could do before the problem? (Please be as specific as you can, for instance, "difficulty reaching over my head, or unable to vacuum") _____

WHAT ARE YOUR PERSONAL GOALS?

_____ To relieve/reduce pain _____ Improve sleep _____ Return to work activities

_____ Resume household chores _____ Resume yard work _____ Resume recreational activities

_____ Regain mobility/increase flexibility Other: _____