Returning Patients Medical Questionnaire: For reassessment of previously treated pathology or injury.

Patient Information		
Name:	Age:	Date:

Changes in Medical History

Have you had a change in your medical history? If yes, describe:

Have you fallen since you last had PT? ☐ Yes ☐ No

During the past month, have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

During the past month, have you been bothered by little or no interest or pleasure in doing things? ☐ Yes ☐ No

Current Symptoms (Please select all that apply):

- ☐ Fever/chills/sweats
- ☐ Changes in appetite
- ☐ Dizziness
- ☐ Changes in bowel or bladder function
- ☐ Poor balance (falls)
- ☐ Difficulty swallowing
- ☐ Headaches
- ☐ Unexplained weight loss
- ☐ Depression
- ☐ Nausea/Vomiting
- ☐ Numbness or Tingling
- ☐ Shortness of breath
- ☐ Increased pain at night

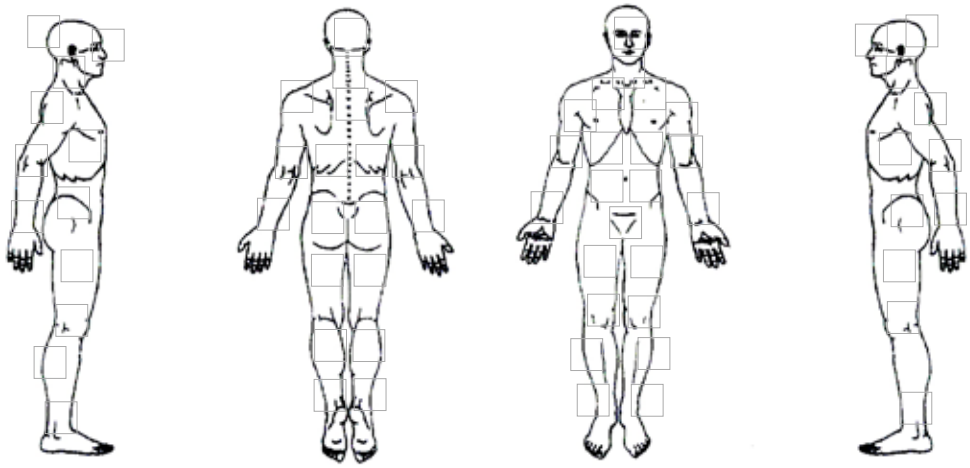
Have you had a recent xray, MRI or other imaging study? ☐ Yes ☐ No

At the present time, would you say that your health is? ☐ Excellent ☐ Very good ☐ Fair ☐ Poor

Please describe your current symptoms:

Body Chart:

Please mark the areas where you feel pain on the chart to the right.



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