Diagnostic testing: (circle all that apply)

None, x-ray, bone scan, MRI, CAT scan, EMG, NCV, other: ______________________________

Results of tests: ____

Prior treatment: (circle all that apply)

Occupational therapy, physical therapy, chiropractic, injection, other: ____________________

Hobbies/Actitivites:

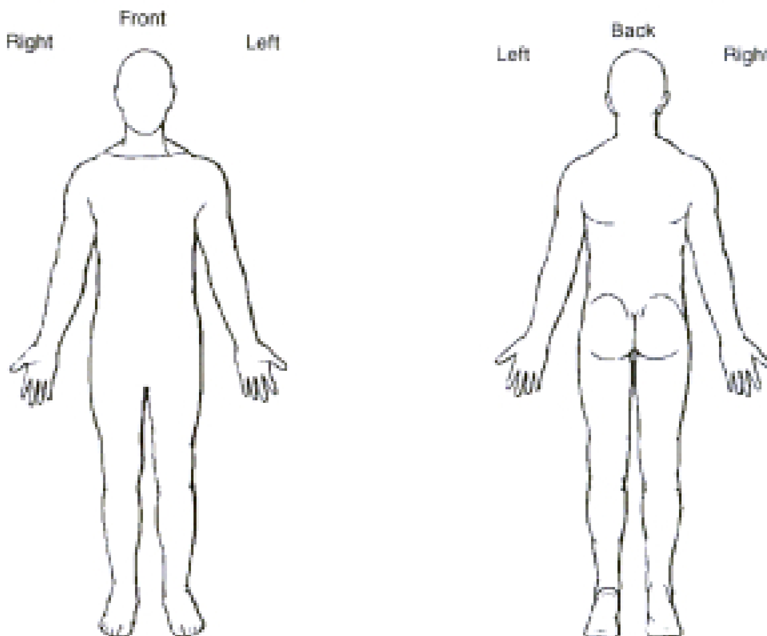
____

What do you hope to achieve from therapy? ______________________________

____

Any additional comments: ____

Please shade the area where you are experiencing pain.



What is your hand dominance? _____ right _____ left

What is your learning preference? _____ demonstration _____ explanation _____ written material
_____ videotape _________ audiotape

Completed by: ______________________ **Therapist/License#:** ______________________

Date: ______________________

PRESENT HISTORY QUESTIONNAIRE

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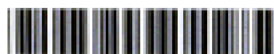

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