



Ph 502.493.3800
4233 Bardstown Road, Suite 100 - C

Fx 502.493.3830
Louisville, Kentucky 40218

Pre-Treatment Questionnaire

Name _____

Primary Care Physician _____ Phone _____

Would you like a copy of your evaluation to be sent to your primary care physician? Y / N

Emergency Contact _____ Phone _____

Medical History:

1. Are you allergic to any medications? Y / N

If yes, please list: _____

2. Are you currently taking any medication? Y / N

If yes, please list: _____

3. Are you, or is there a possibility that you are pregnant? Y / N

4. Have you had any bone / joint surgeries? Y / N

If yes, please list: _____

5. Have you ever had any adverse reactions to heat and/or cold? Y / N

6. Have you been diagnosed as having epilepsy, or other seizure disorder? Y / N

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7. Do you have any metal implants? Y / N

If so, where?

8. Do you have any respiratory problems such as asthma, emphysema or COPD? Y / N

If so, explain _____

9. Do you have a heart condition? Y / N

If so, explain _____

10. Do you have an area of poor circulation? Y / N

If so, explain _____

11. Please list any further information not already discussed that we should be aware of prior to testing and/or treating your condition, ie. Cancer, diabetes, etc...

12. Have you had any physical therapy in the past? Y / N

If so, for what condition and when? _____

I affirm that the information contained on this form is true and correct to the best of my knowledge. I also acknowledge that I have been offered a copy of Bardstown Rd. Physical Therapy Group, Inc.s notice of privacy practices and that I may request a copy at any time.

Patient Signature

Date