

Core Stability & Physical Training

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MEDICAL HISTORY QUESTIONNAIRE

Please Print

Name: _____ Age: _____ Date: _____

Physician: _____

Please list any prior injuries/surgeries: _____

Please list your leisure/fitness activities: _____

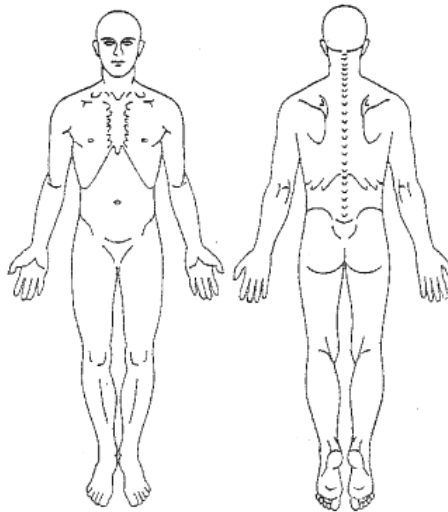
Your goals : _____

What positions/activities make your symptoms worse? _____

Are your symptoms: getting worse improving the same

PAIN DIAGRAM

Please use the following diagram below to indicate where you feel your symptoms currently.
Use the key below to indicate the different types of symptoms.



KEY	
Pins & Needles =	00000
Stabbing =	/////
Burning =	XXXXX
Deep Ache =	zzzzz

Please rate your pain using the following scale:

0	1	2	3	4	5	6	7	8	9	10
(no pain)										(worst imaginable pain)

Today: ____/10 At Best: ____/10 At Worst: ____/10