RELEASE! MANUAL THERAPY

Medical Questionnaire

What is the main complaint you would like to address with treatment at Release! Manual Therapy?

Please be as detailed as possible describing your symptoms:

Do you have any other concerns which may be addressed by treatment here? If so, please describe these.

What activities are you having trouble with because of your symptoms?

What makes your symptoms worse?

What makes your symptoms better?

Have you had any diagnostic imaging or other tests done for this condition? If so, please list with date and results if known.

Have you had any treatment for this condition by other health care practitioners? If so, please list.

Please list all surgeries you have had and the year they were performed.

Please list hospitalizations and whether any included time in ICU.

Please list all medications you are currently taking (prescribed and over the counter) and for what condition(s) you take each.

Are you currently being treated by a physician for any condition or illness? If yes, please list.

Do you have any allergies? If so, what are they?

Is there anything else I should know about your medical history or personal background?

What are your typical daily activities (work, home, recreation)?

How often do you exercise each week and what type of exercise do you do?

How do you relieve stress?