

Ocean Therapy Center Pre-Exam Questionnaire

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank you.

MEDICAL HISTORY

Please check if you have ever had or currently have any of the following:

Asthma/ Bronchitis/ Emphysema	Yes	No	Severe/Frequent Headaches	Yes	No
Shortness of Breath/Chest Pain	Yes	No	Vision / Hearing Difficulty	Yes	No
Coronary Heart Disease/ Angina	Yes	No	Numbness/Tingling	Yes	No
Pacemaker	Yes	No	Dizziness/Fainting	Yes	No
High Blood Pressure	Yes	No	Weakness	Yes	No
Heart Attack/Heart Surgery	Yes	No	Weight Loss/Energy Loss	Yes	No
Blood Disorders	Yes	No	Hernia	Yes	No
Circulation/Vascular Problems	Yes	No	Epilepsy/Seizure	Yes	No
Stroke/TIA	Yes	No	Multiple Sclerosis/Parkinson's	Yes	No
Joint Replacement	Yes	No	Incontinence	Yes	No
Diabetes	Yes	No	Bowel / Bladder Problems	Yes	No
Depression	Yes	No	Neck Injury/Surgery	Yes	No
Cancer/Chemotherapy/Radiation	Yes	No	Shoulder Injury/Surgery	Yes	No
Arthritis	Yes	No	Elbow/Hand Injury/Surgery	Yes	No
Osteoporosis	Yes	No	Back Injury/Surgery	Yes	No
Sleeping Problems/Difficulty	Yes	No	Knee Injury/Surgery	Yes	No
Head Injury	Yes	No	Leg/Ankle/Foot Injury/Surgery	Yes	No

If YES to any of the above, please explain:

List any medications you are currently taking:

Please describe any known allergies:

State your main reason for therapy:

Have you had Therapy for this condition before? If yes, approximately when and where:

What other therapies/ have you tried?

Is today's therapy related to an accident or work related injury?

What caused your pain/problem and approximately when did it start?

Has this pain/problem limited your ability to perform everyday task(s)? Yes No

If YES, please explain:

What are your goals for therapy? Be specific:

All of this information has been reviewed with the patient and/or family:

Signature of Person Completing Form/Date

Staff Signature/Date