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**Front Range Therapies Parker, P.C.**  
Orthopedic and Sports Physical Therapy

**PATIENT HEALTH QUESTIONNAIRE**

Have you had any of the following?	YES	NO
High Blood Pressure	_____	_____
Heart Attack	_____	_____
Heart Murmur	_____	_____
Pacemaker	_____	_____
Stroke	_____	_____
Diabetes	_____	_____
Seizures	_____	_____
Allergies	_____	_____
Reaction to Heat/Cold	_____	_____
Smoke	_____	_____ Packs/Day ___ Years
Cancer	_____	_____ When _____ Type _____

Have you any past or present illnesses we should be aware of? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Any exercise limitations? \_\_\_\_\_

\_\_\_\_\_

Regular exercise routine: \_\_\_\_\_

Have you ever had any plastic surgery that involves implants of any kind? \_\_\_\_\_

\_\_\_\_\_

Current Medications List: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Patient Signature**