

1. Have you ever had a serious injury? Yes or No

Type of Injury:

Date:

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2. Are you interested in being educated with Medical diagnoses, illnesses, or disease?

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3. How do you prefer to receive this information: Video tape, Reading, cassette tape, some one instructing you,

etc. \_\_\_\_\_

4. Do you experience any pain?

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5. Where do you have this pain?

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6. For how long have had this pain?

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7. Do you see any other doctors Cardiologist, Orthopedist, Urologist, etc?

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8. If so, please list:

Name:

Address:

Phone#

Specialty:

Reason:

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9. Do you have any other medical information that you would like to share with us that has not been asked on this questionnaire?

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10. Do you have a Durable Power Of Attorney or Living Will for your health care?

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11. Is there a medical facility that has a copy on record? (hospital or doctors office)

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