Par Q Form

Name: _____ Date: _____

Telephone: _____

Date of Birth:_____ Age: _____

In Case of Emergency Contact: _____ Relationship:_____

Address: _____ Phone: _____

Physician: _____ Specialty: _____

Address: _____ Phone: _____

Are you currently under a doctor's care: Yes ☐ No ☐

If yes, explain: _____

When was the last time you had a physical examination? _____

If you have children, what are the dates of your deliveries?_____

Vaginal Birth? Cesarean Birth? Complications?_____

Please describe your birth experience

_____

_____

Have you been to a Physical Therapist Postpartum or recently? Yes ☐ No ☐

Do you take any medications on a regular basis? Yes ☐ No ☐

If yes, please list medications and reasons for taking: _____

Have you been recently hospitalized? Yes ☐ No ☐

If yes, explain: _____

Are you pregnant? Yes ☐ No ☐

Is your stress level high? Yes ☐ No ☐

Are you moderately active on most days of the week? Yes ☐ No ☐

Do you have any medical condition, pain, injury or concern?

_____

To the best of my knowledge, the above information is true.

Signature _____

Date_____ Witness _____