Medical History Form

Patient Name: ______________________________ Phone Number: ______________________

Height:______ft______in Weight:__________(pounds) Date of injury:______________

Diagnosis as stated to you by your physician: ____

How did this injury/ exacerbation occur? ____

Have you been hospitalized for the present condition? □ Yes □ No If Yes, date: __________________

Have you had surgery for the present condition? □ Yes □ No If Yes, date: _______________________

If yes, surgery type:____

Have you had any falls this past year? □Yes □No If Yes, how many?_____________

Have you received previous treatment for this condition? □ Yes □ No If Yes, date: _____________________

If yes, please summarize:____

Have you ever had any of the following? □ EMG □ CT SCAN □ ULTRASOUND □ MRI □ XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Condition		
Acquired Respiratory Distress Syndrome	□ Yes	□No
Angina	□ Yes	□No
Anxiety or Panic Disorders	□ Yes	□No
Arthritis (RA, OA)	□ Yes	□No
Asthma	□ Yes	□No
Chronic Obstructive Pulmonary Disease (COPD)	□ Yes	□No
Congestive Heart Failure (CHF)	□ Yes	□No
Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain)	□ Yes	□No
Depression	□ Yes	□No
Diabetes	□ Yes	□No
Emphysema	□ Yes	□No
Hearing Impairment	□ Yes	□No
Heart Attack	□ Yes	□No
Multiple Sclerosis	□ Yes	□No
Osteoporosis	□ Yes	□No
Parkinson's Disease	□ Yes	□No
Peripheral Vascular disease	□ Yes	□No
Stroke or TIA	□ Yes	□No
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	□ Yes	□No
Visual Impairment (cataracts, glaucoma, macular degeneration)	□ Yes	□No

Condition		
Allergies	□ Yes	□No
Headaches	□ Yes	□No
Back Injury	□ Yes	□No
Bleeding Disorders	□ Yes	□No
Bowel / Bladder Abnormalities	□ Yes	□No
Cancer	□ Yes	□No
Dizzy or Fainting Spells	□ Yes	□No
Epilepsy or Seizure Disorder	□ Yes	□No
Fracture	□ Yes	□No
Hepatitis A, B, C	□ Yes	□No
Hernia	□ Yes	□No
High Blood Pressure	□ Yes	□No
Hypoglycemia	□ Yes	□No
Immunosuppressant Condition or Medication	□ Yes	□No
Kidney Problems	□ Yes	□No
Liver / Gallbladder Problems	□ Yes	□No
Metal Implants	□ Yes	□No
Nausea / Vomiting	□ Yes	□No
Pacemaker	□ Yes	□No
Pregnancy	□ Yes	□No
Ringing in Your Ears	□ Yes	□No
Sexual Dysfunction	□ Yes	□No
Skin Abnormalities	□ Yes	□No
Smoking	□ Yes	□No
Special Diet Guidelines	□ Yes	□No
Tuberculosis	□ Yes	□No

Please continue to 2nd page

Medical History Form **(page 2)**

Patient Name: ________________________

Are you on any medications? Please list (you may use reverse side): _________________________________

____

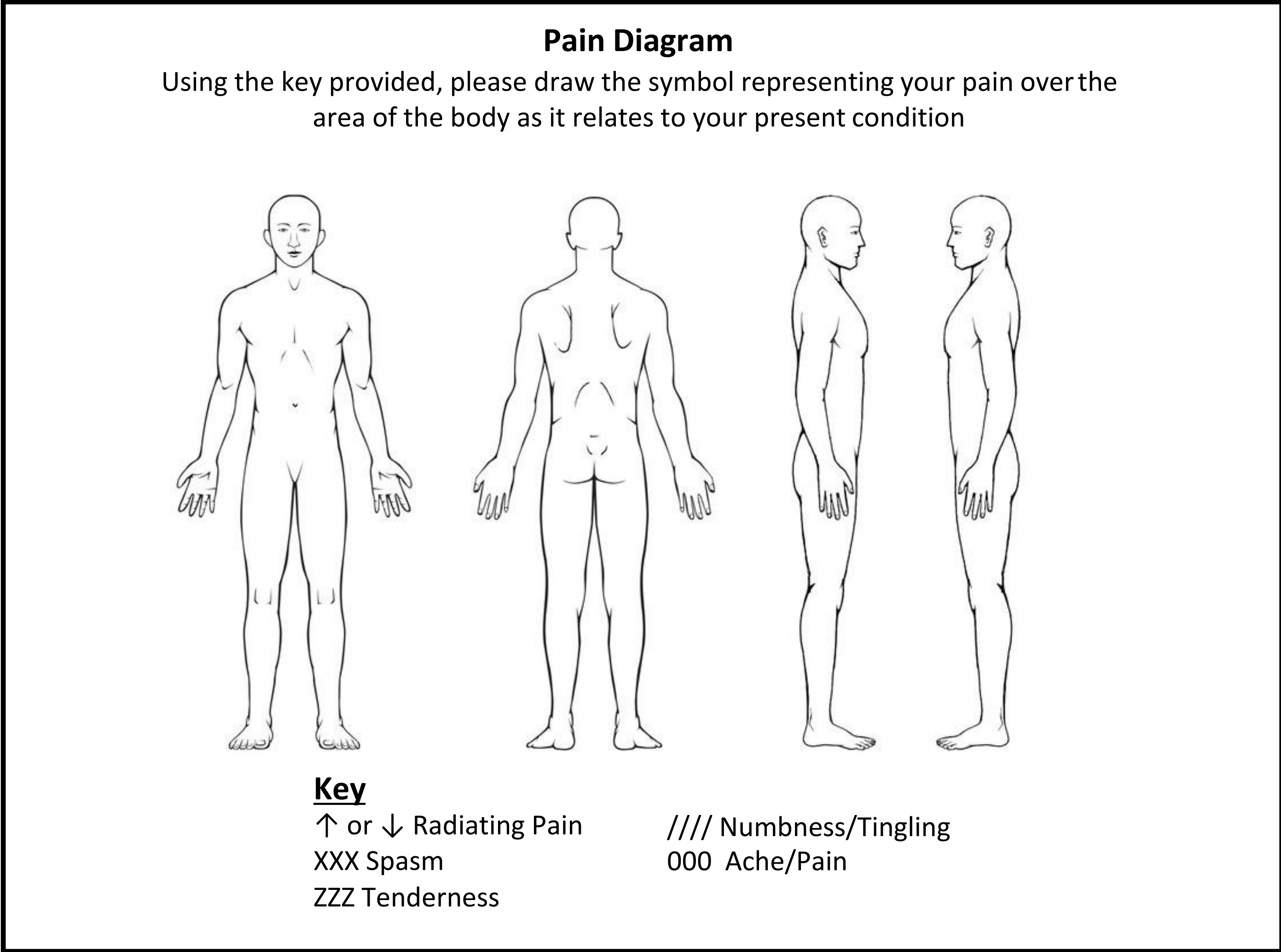
____

To help us understand your symptoms, please circle all that apply.

My pain is worse: in the morning/ during the day/ at night/ constant/ with activity/ during rest

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best_________and at its worst____________



Is there any other information regarding your medical history that we should know about? ________________

____

What is your goal for therapy at this time? ____

____

Signature of Patient or Guardian (if patient is a minor):_________________________________ Date: ______

Signature of Clinician: ____ Date: ______