

Medical History Form

Patient Name: _____ Account 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 MYELOGRAM MRI XRAY

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

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

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

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Please continue to 2nd page

Patient Name: _____

Account Number: _____

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

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

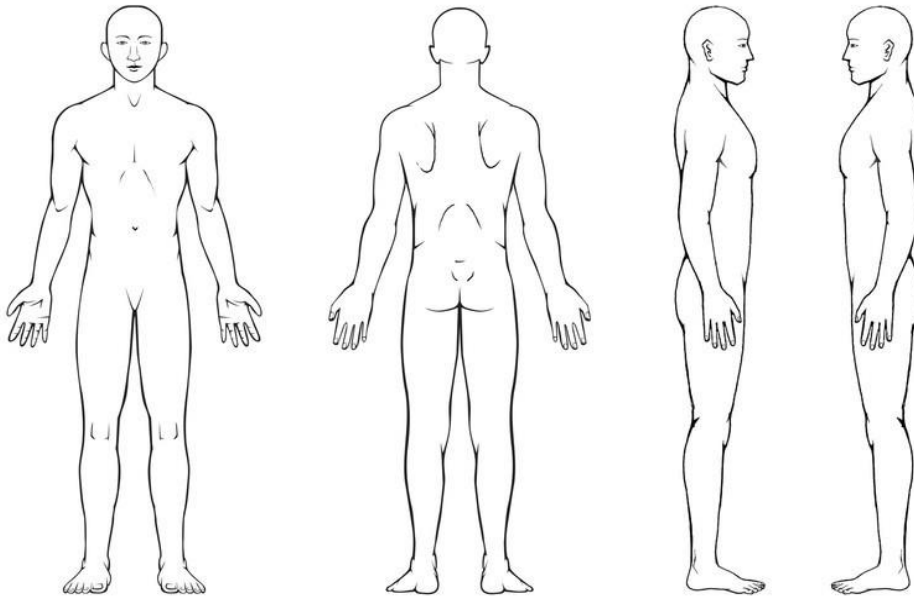
My pain is worse: in the morning/ during the day/ at night/ constant/ with activity/ during rest

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 _____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



Key

↑ or ↓ Radiating Pain

XXX Spasm

ZZZ Tenderness

//// Numbness/Tingling

000 Ache/Pain

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: _____