

# 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Defibrillator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ringing 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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Are you on any medications? Click here if attached:  Attached Please list (you may use reverse side):

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

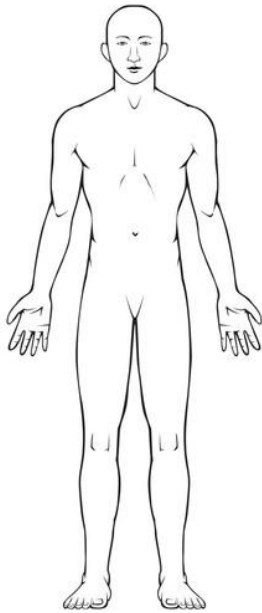
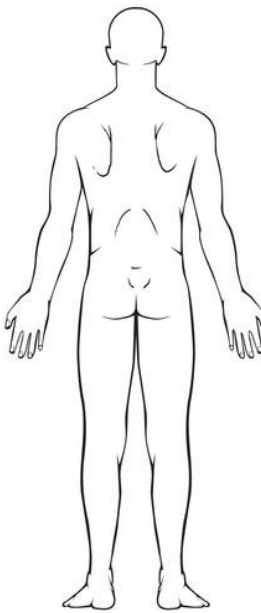


My pain is worse: in the morning/ during the day/ at night/ constant/ with activity/ during rest

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	///// Numbness/Tingling
XXX Spasm	000 Ache/Pain
ZZZ Tenderness	

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: \_\_\_\_\_