

Medical History Form



Name: _____

Age: _____ Sex: _____

Physician's name: _____

Occupation: _____

Date of next M.D. appointment: _____

<p>What is the reason for your visit?</p> <input type="checkbox"/> Headaches <input type="checkbox"/> TMJ <input type="checkbox"/> Neck <input type="checkbox"/> Upper Back <input type="checkbox"/> Low Back <input type="checkbox"/> Arm (R / L) <input type="checkbox"/> Shoulder (R / L) <input type="checkbox"/> Elbow (R / L) <input type="checkbox"/> Wrist (R / L) <input type="checkbox"/> Hand (R / L) <input type="checkbox"/> Finger (R / L hand) <input type="checkbox"/> Thigh (R / L) <input type="checkbox"/> Knee (R / L) <input type="checkbox"/> Ankle (R / L) <input type="checkbox"/> Foot (R / L) <input type="checkbox"/> Toe (R / L foot) <input type="checkbox"/> Other: _____ <p>Any tests done? (list body part)</p> <input type="checkbox"/> X-Ray _____ <input type="checkbox"/> MRI _____ <input type="checkbox"/> Other: _____	<p>When did the condition start? Estimated Date: _____</p> <p>Was the onset <input type="checkbox"/> gradual or <input type="checkbox"/> sudden?</p> <p>How did it start?</p> <input type="checkbox"/> Crushing <input type="checkbox"/> Disease <input type="checkbox"/> Falling <input type="checkbox"/> Lifting <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Twisting <input type="checkbox"/> Work Related <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ <p>Have you been hospitalized for this problem? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list date: _____</p> <p>Is the condition getting</p> <input type="checkbox"/> better <input type="checkbox"/> worse or <input type="checkbox"/> comes and goes?	<p>Who is seeing / has seen you for this condition?</p> <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Chiropractor (# of visits): _____ <input type="checkbox"/> Dentist <input type="checkbox"/> Osteopath <input type="checkbox"/> Podiatrist <input type="checkbox"/> Psychiatrist/ Psychologist <input type="checkbox"/> Physical/ Occupational/ Speech Therapist (# of visits): _____ <input type="checkbox"/> Other: _____ <p>Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you on <input type="checkbox"/> Regular duty or <input type="checkbox"/> Modified/ light duty?</p> <p>What is the condition effecting?</p> <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> Daily Routines Please explain: _____
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List all surgeries, related and unrelated.	Date	List all surgeries, related and unrelated.	Date
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Please check all that apply:

<input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatoid <input type="checkbox"/> Osteo <input type="checkbox"/> Cancer (list type) _____ <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Dislocation (location) _____ <input type="checkbox"/> Drug Allergies _____ <input type="checkbox"/> Elevated Cholesterol <input type="checkbox"/> Fracture (location) _____ <input type="checkbox"/> GI Problems	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV/ AIDS <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker/ Defibrillator <input type="checkbox"/> Pregnant (currently) <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> Seizures <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Skin Allergies: _____ <input type="checkbox"/> Tuberculosis
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Please circle area of pain:

Please circle pain level:
 0 = No Pain, 10 = Emergency
 0 1 2 3 4 5 6 7 8 9 10

Have you had any recent injections? Yes No If yes, when? _____ List body part: _____

List current medications: _____

List current vitamins/ herbal remedies: _____ Do you smoke? Yes No

Do you exercise regularly (3-5 times per week)? Yes No Are you predominantly right or left handed?

Do you have any metals or plastics in your body? Yes No If Yes, where and what type? _____

_____ Have you had any unexplained weight loss/ gain? Yes No

I certify that the above information is as accurate as I know it to be.

Patient signature: _____

Date: _____

Therapist signature: _____

Date: _____