Medical History

Patient Name:_____ Patient Number:_____

Date condition began_____ Date of Surgery (if applicable)_____

Type of Surgery (if applicable)_____

How did you hear about us?_____

What are you therapy goals?_____

Height:_____ _____ inches Weight:_____lbs

Which apply to your situation?

- ☐ Work related injury
- ☐ Motor vehicle accident
- ☐ Recurrence of previous injury
- ☐ Injury related to lifting
- ☐ Athletic/recreational injury
- ☐ Injury related to falling
- ☐ Cause unknown
- ☐ Attorney involvement

Yes	No	
☐	☐	Are you currently working?
☐	☐	Have you had therapy in the past 12 months?
☐	☐	Are you currently receiving home care?
☐	☐	Are you seeing a chiropractor?
☐	☐	Do you participate in regular exercise/sporting activities?
☐	☐	Have you had X-rays for this injury?
☐	☐	Have you had an MRI for this injury?
☐	☐	Have you had injections for this injury?
☐	☐	Have you had any other treatment /tests for this injury?

Rate your symptom intensity in the past 5 days: Symptoms at worst = _____ out of 10

(0 is no pain or symptoms and 10 is worst possible pain or symptoms) Symptoms at best = _____ out of 10

How many times have you fallen in the past 12 months?_____

Yes	No	
☐	☐	Have any falls resulted in injury?

Do you have a history of:

Yes	No		Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Rheumatoid arthritis	☐	☐	Depression
☐	☐	Chest pain/angina	☐	☐	Osteoporosis/osteopenia	☐	☐	Anxiety
☐	☐	High blood pressure	☐	☐	Weakness	☐	☐	Smoking
☐	☐	Heart disease	☐	☐	Headaches	☐	☐	If female, are you pregnant?
☐	☐	Heart attack	☐	☐	Concussions	☐	☐	Cellulitis/lymphedema
☐	☐	Heart palpitations	☐	☐	Vertigo	☐	☐	Seizures/epilepsy
☐	☐	Pacemaker/defibrillator	☐	☐	Asthma/breathing problems	☐	☐	Visual impairment
☐	☐	Stroke/TIA	☐	☐	COPD/lung disease	☐	☐	Hearing impairment
☐	☐	Shortness of breath	☐	☐	Thyroid problems	☐	☐	Hernia
☐	☐	Blood clotting disorder	☐	☐	Liver gall bladder problems	☐	☐	Latex allergy
☐	☐	Cancer	☐	☐	Hepatitis/HIV	☐	☐	Other allergies
☐	☐	Recent fractures	☐	☐	Kidney problems	☐	☐	Auto-Immune Disorder (list)
☐	☐	Joint replacement	☐	☐	Parkinson's Disease	☐	☐	Other Neurologic Conditions (list)
☐	☐	Arthritis	☐	☐	Multiple sclerosis	☐	☐	Surgeries (list)

Other conditions not listed:_____

_____

_____

In the past 3 months have you experienced:

Yes	No		Yes	No		Yes	No	
☐	☐	Change in health	☐	☐	Repiratory infection	☐	☐	Fever/chills/sweats
☐	☐	Unexpected weight change	☐	☐	Dizziness/fainting	☐	☐	Change in bowel/bladder function
☐	☐	Numbness/tingling	☐	☐	Sexual dysfunction	☐	☐	Change in appetite
☐	☐	Urinary tract infection	☐	☐	Nausea/vomiting	☐	☐	Other allergies (list)

MEDICATION LIST			
MEDICATION	**DOSAGE**	**METHOD**	**FREQUENCY**
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other: