



PATIENT MEDICAL HISTORY

Name: _____ Referring Physician _____

Family Physician: _____ Date of 1st Dr. Visit for this injury: _____

Returned to Work after this injury: Yes No If yes, Date: _____

Is an attorney involved in this case? Yes No If yes please provide attorney's name & phone number below:

Occupation: _____ Have you had surgery for this injury? Yes No

Number of surgeries: 1 2 3 4 Other Type of Surgery: _____

Are you currently taking any prescription or non-prescription medications? Yes No

Anti-Inflammatories Yes No List Medications: _____

Muscle Relaxers Yes No _____

Pain Medication Yes No _____

Have you had any of the following medical or rehabilitative services for this injury?

Chiropractor	<input type="checkbox"/> Yes <input type="checkbox"/> No	CT Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No
EMG/NCS	<input type="checkbox"/> Yes <input type="checkbox"/> No	General Practitioner	<input type="checkbox"/> Yes <input type="checkbox"/> No
Massage Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No
Myelogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologist	<input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedist	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Podiatrist	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Room Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	X-Rays	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other: _____

Do you now have or have you ever had any of the following? Please check Yes or No.

Asthma, Bronchitis, or Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of Breath/Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Energy Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary Heart Disease or Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack or Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clot/Emboli	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Injury/Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shoulder Injury/Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid/Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Elbow/Hand Injury/Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back Injury/Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No

PATIENT MEDICAL HISTORY CONTINUED

Infectious Diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	Knee Injury/Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leg/Ankle/Foot Injury/Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer or Chemotherapy/Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hip Injury/Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Swollen Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness/Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleeping Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emotional/Psychological Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel or Bladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other information that will assist us in your care _____

Are you aware of what your diagnosis is? Yes No

What are your expectations/goals while in this program?

Patient/Guardian Signature: _____

Date: _____

Therapist Signature: _____

Date: _____