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	□Yes	□No	CT Scan	□Yes	□No
EMG/NCS	□Yes	□No	General Practitioner	□Yes	□No
Massage Therapy	□Yes	□No	MRI	□Yes	□No
Myelogram	□Yes	□No	Neurologist	□Yes	□No
Occupational Therapy	□Yes	□No	Orthopedist	□Yes	□No
Physical Therapy	□Yes	□No	Podiatrist	□Yes	□No
Emergency Room Care	□Yes	□No	X-Rays	□Yes	□No

Other: _____

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

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

PATIENT MEDICAL HISTORY CONTINUED

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

Other information that will assist us in your care_____

_____

Are you aware of what your diagnosis is? □Yes □No HEIGHT:_____WEIGHT:_____

What are your expectations/goals while in this program?

_____

_____

Patient/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____