Name:___________________________________ Date: ____________________

Existing or Relevant Previous Conditions

Please Circle "Yes or No"

Condition		Condition		Condition	
Allergies	YES / NO	Dizzy Spells	YES / NO	MRSA	YES / NO
Anemia	YES / NO	Emphysema / Bronchitis	YES / NO	Multiple Sclerosis	YES / NO
Anxiety	YES / NO	Fibromyalgia	YES / NO	Muscular Disease	YES / NO
Arthritis	YES / NO	Fractures	YES / NO	Osteoporosis/Osteopenia	YES / NO
Asthma	YES / NO	Gallbladder Problems	YES / NO	Parkinson's	YES / NO
Autoimmune Disorder	YES / NO	Headaches	YES / NO	Rheumatoid Arthritis	YES / NO
Cancer	YES / NO	Hearing Impairment	YES / NO	Seizures	YES / NO
Cardiac Conditions	YES / NO	Hepatitis	YES / NO	Smoking	YES / NO
Cardiac Pacemaker	YES / NO	High Cholesterol	YES / NO	Speech Problems	YES / NO
Chemical Dependency	YES / NO	High / Low Blood Pressure	YES / NO	Strokes	YES / NO
Circulation Problems	YES / NO	HIV / AIDS	YES / NO	Thyroid Disease	YES / NO
Currently Pregnant or Trying to become pregnant	YES / NO	Incontinence	YES / NO	Tuberculosis	YES / NO
Depression	YES / NO	Kidney Problems	YES / NO	Vision Problems	YES / NO
Diabetes	YES / NO	Metal Implants	YES / NO	Sexual Abuse/ Trauma	Yes/ No
Recurrent UTI	YES/ NO	OTHER:			

Please list your MEDICATION in the table provided below or attach a list of all medications

Name	Dose	Frequency

Please list surgeries and the date of surgery:

____

Patient Signature: ___________________________________ Date: ______________________

Patient Medical History

Name:_______________________________ Today's Date:________________

Referring Physician:___________________ Date of Injury/Onset:___________

How Injury happened: (circle one) Unknown/Activity/sports/Car accident/Work injury

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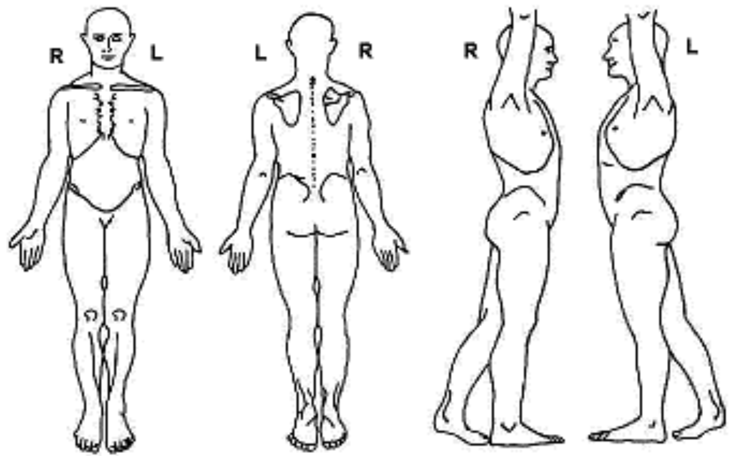
Please mark the location of the symptoms you are currently feeling on the diagram:

Height__________
Weight_________

X for Pain
O for Numbness
--- for Tingling



On a scale from 0-10, 0 being no pain, 5 being moderate pain, and 10 being the worst pain imaginable, please rate your pain based on the last 30 days.

	(no pain)					(moderate)					(severe pain)
TODAY	0	1	2	3	4	5	6	7	8	9	10
LOWEST (or best)	0	1	2	3	4	5	6	7	8	9	10
HIGHEST (or worst)	0	1	2	3	4	5	6	7	8	9	10

FALL HISTORY: Circle # of falls in the past 2 year? 0 1 2 3 MORE **Injured Y/ N**

Circle what best describes your pain:
Constant Occasional Sharp Dull Aching Shooting Burning

Signature:____**Date:** _______________