



Patient Medical History

Name: _____

Date: _____

Referring Physician: _____

Date of first Doctor visit for this injury: _____

Family Physician: _____

Surgery for this injury: Yes No

Date of Surgery: _____

Working? Yes No If No, last date worked due to this injury: _____

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

Anti-inflammatories: _____ Muscle Relaxers _____ Pain Medication _____

List all medication: _____

Are you allergic to: Medications Latex Adhesives

List all allergies: _____

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

	YES		YES
Chiropractor	<input type="checkbox"/>	MRI	<input type="checkbox"/>
EMG/NCV	<input type="checkbox"/>	CT-Scan	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	Orthopedist	<input type="checkbox"/>
Myelogram	<input type="checkbox"/>	Neurologist	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	Podiatrist	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	X-Ray	<input type="checkbox"/>
Emergency Room Care	<input type="checkbox"/>	General Practitioner	<input type="checkbox"/>

Do you now have or have you ever had ANY of the following?

	YES		YES
Asthma, Bronchitis, Emphysema	<input type="checkbox"/>	Emotional/Psychological	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	Vision/Hearing Problems	<input type="checkbox"/>
Chest Pain (Angina)	<input type="checkbox"/>	Numbness/Tingling	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	Bowel/Bladder Problems	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Weakness	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>
Do you have a Pacemaker?	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>
Stroke or TIA	<input type="checkbox"/>	Pins or Metal Implants	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>
Blood Clot / Emboli	<input type="checkbox"/>	Neck Injury/Surgery	<input type="checkbox"/>
Epilepsy / Seizures	<input type="checkbox"/>	Shoulder Injury/Surgery	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	Elbow/Hand Injury/Surgery	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Back Injury/Surgery	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Knee Injury/Surgery	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	Foot/Ankle Injury/Surgery	<input type="checkbox"/>
Sleeping Difficulty	<input type="checkbox"/>	Are You Pregnant?	<input type="checkbox"/>
Gout	<input type="checkbox"/>	Do you smoke?	<input type="checkbox"/>

Other: _____

Patient / Guardian Signature: _____ Date: _____