Submit by Email Print Form

PATIENT MEDICAL HISTORY

NAME_____ **AGE**_____ **DATE of NEXT DR'S VISIT**_____

ARE YOU PRESENTLY WORKING? ☐ YES ☐ NO ☐ LIGHT/MODIFIED ☐ REGULAR

ARE YOU ☐ RIGHT or ☐ LEFT **HANDED?**

WHICH AREA IS THE PROBLEM? ☐ RIGHT ☐ LEFT

☐ HEADACHE ☐ TMJ ☐ UPPER BACK ☐ LOW BACK ☐ ARM ☐ LEG ☐ SHOULDER

☐ ELBOW ☐ WRIST ☐ HAND ☐ FINGER ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT ☐ TOE

OTHER _____

HOW DID THIS PROBLEM BEGIN?

☐ LIFTING ☐ TWISTING ☐ FALLING ☐ CRUSHING ☐ MOTOR VEHICLE ☐ UNKNOWN

OTHER _____

DATE OF INJURY OR WHEN PROBLEM FIRST OCCURRED? _____

WAS THE ONSET ☐ SUDDEN or ☐ GRADUAL**?**

DID THE PROBLEM RECENTLY BECOME WORSE? ☐ YES ☐ NO

ARE YOU CURRENTLY BEING SEEN BY ANY OF THE FOLLOWING:

☐ MEDICAL DOCTOR ☐ SPEECH THERAPIST ☐ DENTIST ☐ OSTEOPATH

☐ PSYCHIATRIST/PSYCHOLOGIST ☐ PHYSICAL/OCCUPATIONAL THERAPIST

☐ CHIROPRACTOR

IF YOU HAVE BEEN SEEN BY ANY OF THE ABOVE DURING THE PAST SIX MONTHS, PLEASE DESCRIBE FOR WHAT REASON:

_____

_____

_____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS FOR THIS CONDITION?

☐ XRAYS ☐ MRI ☐ CAT SCAN ☐ BONE SCAN ☐ NONE OTHER: _____

HAVE YOU BEEN HOSPITALIZED FOR THIS PROBLEM? ☐ YES ☐ NO

DATE OF HOSPITALIZATION _____

PLEASE LIST ANY SURGERIES AND ANY CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED (IN/OUT PATIENT):

DATE	REASON
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HAVE YOU EVER BEEN CLINICALLY DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?

YES	NO		YES	NO	
☐	☐	Seizures	☐	☐	Cancer
☐	☐	Tuberculosis	☐	☐	Hepatitis
☐	☐	Kidney Disease	☐	☐	High Blood Pressure
☐	☐	Respiratory Problems	☐	☐	GI Problems
☐	☐	Rheumatoid Arthritis	☐	☐	Other Arthritic Conditions
☐	☐	Elevated Cholesterol	☐	☐	Diabetes
☐	☐	Depression	☐	☐	Chemical Dependency
☐	☐	Heart Disease/History of	☐	☐	Other: _____

DO YOU SMOKE? ☐YES ☐NO **ARE YOU PREGNANT?** ☐YES ☐NO

DO YOU LEAD A SEDENTARY LIFESTYLE? ☐YES ☐NO

HAVE YOU EVER HAD A FRACTURE OR DISLOCATION? ☐YES ☐NO

IF YES, WHICH BODY PART? _____

DO YOU HAVE ANY OF THE FOLLOWING METALS OR PLASTICS IN YOUR BODY?

☐RODS ☐PINS ☐PLATES ☐STAPLES ☐ARTIFICIAL JOINTS ☐METAL ☐NONE

LOCATION: _____

LIST ANY CURRENT MEDICATIONS OR RECENT INJECTIONS:

_____

_____

LIST ANY ALLERGIES TO DRUGS:

_____

_____

PATIENT SIGNATURE _____ **DATE** _____

PARENT OR AUTHORIZED REPRESENTATIVE _____

RELATIONSHIP _____