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
___ ___ Cancer
___ ___ Hepatitis
___ ___ High Blood Pressure
___ ___ GI Problems
___ ___ Other Arthritic Conditions ___ ___ Diabetes
___ ___ Chemical Dependency
___ ___ Other: _____

ARE YOU PREGNANT? ___YES **___**NO

YES NO
___ ___ Seizures
___ ___ Tuberculosis
___ ___ Kidney Disease
___ ___ Respiratory Problems ___ ___ Rheumatoid Arthritis ___ ___ Elevated Cholesterol ___ ___ Depression
___ ___ Heart Disease/History of
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
_____