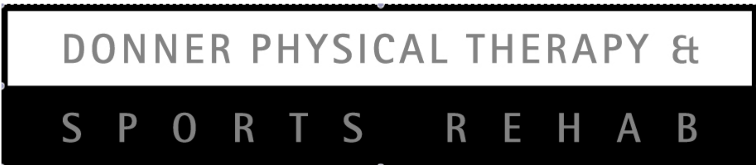

New Patient Medical History Form

Name:____________________________________DOB:_________Referring MD:_________________________

Age:_______ Gender: M / F Retired? Yes / No Occupation:_____________________________

What is your chief complaint?____

____

What date did your present symptoms start?____

How did your problem start?____

Was this injury related to a motor vehicle accident? Yes No

Have you had surgery for this problem? Yes No If yes, give date of surgery:_________________________

Type of surgery:____

Have you had other treatments for this problem (acupuncture, chiropractic)? ____________________________

Any Diagnostic tests done for this problem? X-ray MRI Other _____________ If so, please describe outcome of tests:____

PAST MEDICAL HISTORY:

	Y	N		Y	N
Arthritis	_____	_____	High Blood Pressure	_____	_____
Asthma	_____	_____	Osteoporosis	_____	_____
Heart Disease	_____	_____	Diabetes	_____	_____
Head Trauma	_____	_____	Stroke	_____	_____
Cancer	_____	_____	Rheumatoid Arthritis	_____	_____
(if yes, what type, when?____________________			Pacemaker?	_____	_____

Do you have any of the following metals or plastics in your body? Rods_____ Pins_____ Plates_____

Joint replacements _____ If Yes, where? ____

Do you smoke? Yes No Are you currently pregnant? Yes No Do you exercise? Yes No

What kind of exercise do you do?____________________________ How often?__________________________

On the scales below, please circle the number that best represents the severity of your pain:

Average for the last 48 hours (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Need to go to the ER)

Worst over the last 48 hours (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Need to go to the ER)

Best over the last 48 hours (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Need to go to the ER)

List up to 3 activities that you are unable to do or are having difficulty with as a result of your problem:

____

____

List any medications you are taking____

____

Patient Signature____ Date________________