Medical History Form

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 medications: ____

List all allergies:____

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

Chiropractor	☐	MRI	☐
EMG/NCV	☐	CT-Scan	☐
Massage Therapy	☐	Orthopedist	☐
Myelogram	☐	Neurologist	☐
Occupational Therapy	☐	Podiatrist	☐
Physical Therapy	☐	X-Ray	☐
Emergency Room Care	☐	General Practitioner	☐

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

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

Other: ____

Patient/Guardian Signature:____________________________________ Date:_________________