MEDICAL HISTORY

Name: ______________________________________ Date; ________________________

Who is your Primary Care Physician?____

1. During the past 3 months have you been seen by (check all that apply)?

❑ Medical Doctor (MD) ❑ Chiropractor ❑ Physical Therapist ❑ Massage Therapist
❑ Acupuncturist ❑ Osteopath (DO) ❑ Emergency Room Physician

2. Have you EVER been diagnosed as having any of the following conditions (Please check all that apply)?

❑ Cancer ❑ Diabetes (sugar) ❑ Kidney Disease ❑ Heart Attack
❑ Multiple Sclerosis ❑ Epilepsy/Seizures ❑ High Blood Pressure ❑ Rheumatoid Arthritis
❑ Anemia ❑ Asthma ❑ Other Arthritic conditions ❑ Fibromyalgia
❑ Emphysema ❑ Depression/Anxiety ❑ Osteoporosis/Osteopenia ❑ Hepatitis
❑ Stroke ❑ Thyroid Problems ❑ Tuberculosis
❑ Dependence on drugs/alcohol ❑ Other (please list) ______________________
____

3. Do you presently have any of the following ?

❑ Productive Cough ❑ Night Sweats ❑ Weight Loss
❑ Coughing Up Blood ❑ Fever ❑ Lethargy/Weakness

4. Occupation: ________________________________ Job Duties:________________________________

Is your current condition preventing you from working in your regular job? ❑ Yes ❑ No

If yes, are you working light duty: ❑ Yes ❑ No Performing a different job? ❑ Yes ❑ No

Out of work? ❑ Yes ❑ No Is your goal to return to your regular job? ❑ Yes ❑ No

5. Hobbies: ____

6: Please list all surgeries, including year: ____
____

7. Please list any broken bones you have had and when: ______________________________________
____

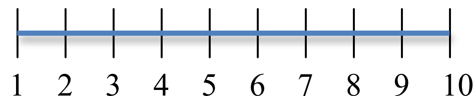
8. For women: Are you pregnant ❑ Yes ❑ No Are you possibly pregnant? ❑ Yes ❑No

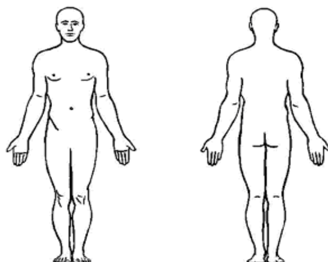
9. Please list any **Over-The-Counter** medication you are presently taking:________________________________
____

10. Please list all **PRESCRIPTION** medications you are presently taking: ______________________________
____

11. At this time would you say your health is ❑ Excellent ❑ Good ❑ Fair ❑ Poor

12. Please rate your typical pain on the following scale:





X = Pain O = Numbness