

Patient Medical History Form

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and ask your therapist to assist you. Thank you!

Name: _____ Age: _____

Leisure Activities: _____ Occupation: _____

How did you hear about our clinic? (check all that apply) Doctor TV (Live at Five) phone book Friend / Family

Name of Friend/Family: _____ other source: _____

What are we seeing you for today? _____

List 2-4 things that you cannot do at this time:

1. _____ 2. _____
3. _____ 4. _____

Is this work related: YES NO

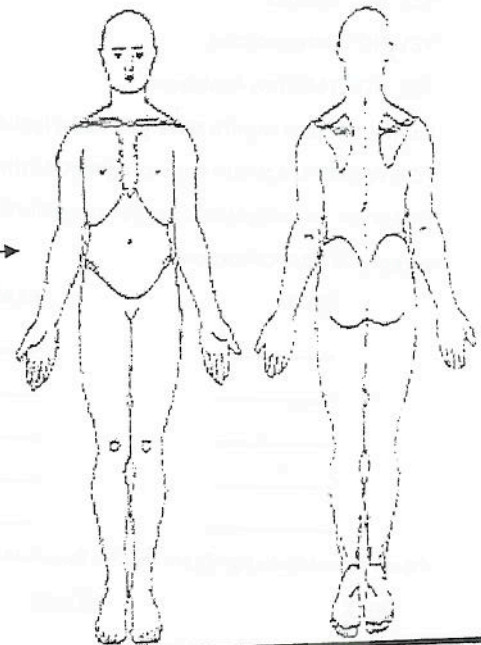
Is this related to an auto accident: YES NO

Please circle your level of Pain:

0 1 2 3 4 5 6 7 8 9 10

0 being no pain.....10 emergency room pain

PLEASE DRAW in your pain →
Include all areas



Have you recently noted:

- | | |
|----------------------------------|----------------------------|
| YES NO Weight Loss/Gain | YES NO Nausea/Vomiting |
| YES NO Dizziness/Lightheadedness | YES NO Fatigue |
| YES NO Weakness | YES NO Fever/Chills/Sweats |
| YES NO Numbness or tingling | YES NO Headaches |

ALLERGIES: List any medication(s) you are allergic to: _____

Are you Latex sensitive? Yes No List any other allergies we should know about: _____

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Please check (v) any of the following whose care you're under:

- | | | |
|----------------------|--------------------------------|------------------------|
| ____ Medical Dr (MD) | ____ Psychiatrist/Psychologist | ____ Massage Therapist |
| ____ Osteopath | ____ Physical Therapist | Other: _____ |
| ____ Dentist | ____ Chiropractor | |

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.): _____



Have you EVER been diagnosed with any of the following conditions?

- YES NO Cancer. IF YES, describe what kind: _____
- YES NO Heart Problems YES NO High Blood Pressure
- YES NO Circulation Problems YES NO Asthma
- YES NO Emphysema/Bronchitis YES NO Chemical Dependency (i.e., alcoholism)
- YES NO Thyroid Problems YES NO Diabetes
- YES NO Multiple Sclerosis YES NO Osteoarthritis / Rheumatoid Arthritis (circle one)
- YES NO Other Arthritic Conditions YES NO Depression
- YES NO Hepatitis YES NO Tuberculosis
- YES NO Stroke YES NO Kidney Disease
- YES NO Anemia YES NO Epilepsy
- YES NO Osteoporosis YES NO Osteopenia
- YES NO TMJ (Jaw Problems) YES NO Other: _____

During the past month have you been feeling down, depressed or hopeless? YES NO

FOR WOMEN: Are currently pregnant or think you might be pregnant? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE	REASON FOR SURGERY/HOSPITALIZATION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

- YES NO Aspirin YES NO Tylenol YES NO Decongestants YES NO Antacid
- YES NO Advil/Motrin/Ibuprofen YES NO Laxatives YES NO Antihistamines YES NO Vitamins/Mineral Supplements

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

- _____
- _____
- _____
- _____
- _____
- _____

Are you a Smoker? YES NO How many packs of cigarettes do you smoke a day? _____

What position do you sleep in? (circle all that apply) back / side / stomach Do you have sleep apnea? YES NO

Patient Signature & Date: _____