Client #_____

Medical History Form

GENERAL INFROMATION:

Name:_____ Date:___/___/_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:(____)_____ Cell ( ) Home ( ) Work ( )
Age:_____ Sex: _____ Height:_____Weight:_____
Physician: _____ Diagnosis: _____
Date of Injury or Condition Onset: ___/___/___/_____
Insurance Carrier:_____ Claim No: _____
Claims Adjuster:_____ Phone No: (___)_____

1. Has your doctor ever said you have any cardiovascular problems? Yes ( ) No ( )
2. Do you frequently suffer from chest pains? Yes ( ) No ( )
3. Have you ever had a heart attack? Yes ( ) No ( )
4. Do you ever experience an irregular or racing heart rate during exercise or at rest? Yes ( ) No ( )
5. Do you often feel faint or have spells of severe dizziness? Yes ( ) No ( )
6. Has a doctor ever said that your blood pressure is too high? Yes ( ) No ( )
7. Do you often have difficulty breathing? Yes ( ) No ( )
8. Has a doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise, or might be aggravated with exercise? Yes ( ) No ( )
9. I there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to? Yes ( ) No ( )
10. Are you over age 65 and not accustomed to vigorous exercise? Yes ( ) No ( )
11. Are you diabetic? Yes ( ) No ( )
12. Are you pregnant? Yes ( ) No ( )

MEDICAL INFROMATION:

1. Date of last physician visit: ____/____/_____
2. List any medications you are now taking and the reason for which they were prescribed
   _____
   _____
   _____
   _____
3. Describe your condition: _____
   _____
4. List any surgical procedures you have undergone: _____
   _____
5. Have you received physical therapy or chiropractic care? ( ) Yes ( ) No
   If yes; Discharge Date:____/____/_____
6. Do you or any member of your immediate family (mother, father, sister, or brother) been diagnosed with:
   Heart Disease: _____
   Diabetes: _____
   Hypertension: _____
   Stroke: _____
   High Cholesterol: _____
   Obesity: _____
   Hyperthyroidism: _____
7. How many hours a week do you work? 20 30 40 >40
8. How do you spend most of your time at work?
   ( ) Sitting ( ) Standing ( ) Carrying Loads ( ) Driving ( ) Walking
9. Do you smoke or vape Tobacco? ( ) Yes ( ) No
10. Are you a valid licensed medical marijuana patient? ( ) Yes ( ) No State:_____
    Medical Marijuana Prescribing Physician:_____ Last Visit: ____/____/_____
11. How many times a week do you engage in moderate or strenuous exercise for at least 30 minutes?
    ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) >5
12. Do you have any pain when exercising? ( ) Yes ( ) No If yes, rate on a scale of 1-10 _____

Name:_____

Signature: _____ Date:____/____/_____

In case of emergency notify the following person:

Name:_____ Phone: (Home)_____
Address:_____ (Work)_____
City:_____ State:_____ Zip:_____