Patient Medical History

Patient Name: _____Date of Birth: _____

Are you currently taking any prescription or non-prescription medications? Yes / No

If Yes, please list all medications

_____

_____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

Chiropractor	Yes	No	CT Scan	Yes	No
EMG/NCV	Yes	No	General Practitioner	Yes	No
Massage Therapy	Yes	No	MRI	Yes	No
Myelogram	Yes	No	Neurologist	Yes	No
Occupational Therapist	Yes	No	Orthopedist	Yes	No
Physical Therapist	Yes	No	Podiatrist	Yes	No
Emergency Room	Yes	No	X-Rays	Yes	No

Other:

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General Health Information: Do you know or have you had ANY of the following? (circle all that apply)

Asthma, Bronchitis, or Emphysema	Yes	No	Severe or Frequent Headaches	Yes	No
Shortness of Breath/Chest Pain	Yes	No	Vision or Healing Difficulties	Yes	No
Coronary Heart Disease or Angina	Yes	No	Numbness and/or Tingling	Yes	No
Pacemaker	Yes	No	Dizziness or Fainting	Yes	No
High Blood Pressure	Yes	No	Ringing in ears	Yes	No
Heart Attack or Surgery	Yes	No	Weakness	Yes	No
Stroke/TIA	Yes	No	Weight Loss/Energy Loss	Yes	No

Blood Clot/Emboli	Yes	No	Hernia	Yes	No
Epilepsy/Seizures	Yes	No	Tuberculosis	Yes	No
Thyroid Trouble/Goiter	Yes	No	Allergies	Yes	No
Anemia	Yes	No	Any pins or metal implants	Yes	No
Infection Disease	Yes	No	Joint Replacement	Yes	No
Diabetes	Yes	No	Neck Injury/Surgery	Yes	No
Cancer or Chemotherapy/Radiation	Yes	No	Shoulder Injury/Surgery	Yes	No
Arthritis/Swollen Joints	Yes	No	Elbow/Hand Injury or Surgery	Yes	No
Osteoporosis	Yes	No	Back Injury/Surgery	Yes	No
Gout	Yes	No	Knee Injury/Surgery	Yes	No
Sleeping problems/difficulties	Yes	No	Leg/Ankle/Foot Injury or Surgery	Yes	No
Emotional/Psychological Problems	Yes	No	Are you Pregnant	Yes	No
Bowel or Bladder Problems	Yes	No	Do you smoke	Yes	No

PATIENT SIGNATURE: _____ DATE:

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