

MEDICAL HISTORY FORM

Diagnosis as stated to you by your physician: _____ Date of onset: _____

How did this injury/exacerbation occur: _____

 Have you been hospitalized for the present condition? Yes No If Yes, date: _____

 Have you had surgery for the present condition? Yes No If Yes, date: _____

 Have you received previous treatment for this condition? Yes No If Yes, date: _____

If yes, please summarize: _____

Are you currently receiving or have you received in the last 30 days any home health, medical or chiropractic services rendered to you by any other agency, organization or individual? If yes, please summarize: _____

Are you on any medications? Please list (you may use reverse side): _____

 Have you ever had any of the following? EMG CT SCAN MYELOGRAM MRI XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fracture	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Metal Implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respiratory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis A, B, C	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bowel / Bladder Abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver / Gallbladder Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexual Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin Abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea / Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No

List: _____

Other: _____

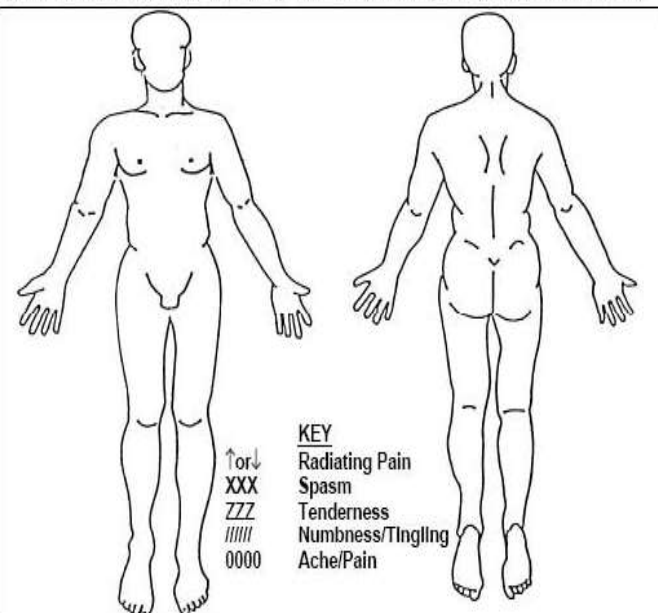
(Continue on back if needed)

Ringling in your ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Special Diet Guidelines	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypoglycemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Surgeries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
List w/ dates:	_____	

Please circle all that may apply. My pain is worse:
 in the morning / during the day / at night / constant / with activity / during rest

On a scale of 0 to 10,
 (0 being no pain and 10 being unbearable pain requiring hospitalization)
 Please rate your pain at its best _____ and at its worse _____

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.



Signature of Patient or Guardian (if patient is a minor): _____ Date: _____

 Relationship to patient: self guardian other: _____

Clinician's Signature: _____ Date: _____