



PATIENT MEDICAL HISTORY FORM

Name: _____ Treating Physician: _____

Primary Care Physician: _____ Date of 1st Doctors Visit for this Injury: _____

Last Day Worked Due to this Injury (if applicable): _____

Date Returned to Work after Injury (if applicable): _____

Have you retained an attorney as a result of your injury? YES NO

Referral Source: Surgeon Rehab MD Other: _____

Have you had Surgery for this Injury? YES NO Number of Surgeries: _____

Type of Surgery(ies): _____

Have you had any of the following diagnostic, medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	_____	_____	General Practitioner	_____	_____
EMG/NCV	_____	_____	CT Scan	_____	_____
Massage Therapy	_____	_____	MRI	_____	_____
Myelogram	_____	_____	Neurologist	_____	_____
Occupational Therapy	_____	_____	Orthopedist	_____	_____
Physical Therapy	_____	_____	Podiatrist	_____	_____
Emergency Room	_____	_____	X-Rays	_____	_____

Do you now or have you ever had any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	_____	_____	High Blood Pressure	_____	_____
Anemia	_____	_____	Shortness of Breath/Chest Pain	_____	_____
Heart Attack or Surgery	_____	_____	Diabetes	_____	_____
Coronary Heart Disease or Angina	_____	_____	Thyroid Trouble/Goiter	_____	_____
Gout	_____	_____	Cancer/chemotherapy/Radiation	_____	_____
Dizziness or Fainting	_____	_____	Weakness	_____	_____
Emotional/Psychological Problems	_____	_____	Infectious Diseases	_____	_____
Hernia	_____	_____	Bowel or Bladder Problems	_____	_____
Numbness or Tingling	_____	_____	Allergies	_____	_____
Severe or Frequent Headaches	_____	_____	Elbow/Hand Injury	_____	_____
Osteoporosis	_____	_____	Vision or Hearing Difficulties	_____	_____

	YES	NO		YES	NO
Neck Injury/Surgery	_____	_____	Stroke/TIA	_____	_____
Sleeping Problems/Difficulties	_____	_____	Back Injury/Surgery	_____	_____
Blood Clot/Emboli	_____	_____	Leg/Ankle/Foot Injury/Surgery	_____	_____
Knee Injury/Surgery	_____	_____	Epilepsy/Seizures	_____	_____
Do you have a Pacemaker?	_____	_____	Arthritis/Swollen Joints	_____	_____
Varicose Veins	_____	_____	Any Pins or Metal Implants?	_____	_____
Are You Pregnant?	_____	_____	Joint Replacement	_____	_____
Weight Loss/Energy Loss	_____	_____	Do You Smoke?	_____	_____

Please list any additional information that would assist us in providing care to you?

Are you aware of your diagnosis (what you are being treated for at our clinic)? Yes No

What are your expectations/goals?

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Patient/Legal Guardian Signature: _____ **Date:** _____

Patient/Legal Guardian Name: _____

Therapist's Signature: _____ **Date:** _____

FOR THERAPIST USE ONLY:

Height: _____ **Weight:** _____ **BMI:** _____