Patient Medical History

Patient Name: _____ **Condition Begin Date** ____ / ____ / _____

Work Status: Full Time / Part Time / Off Duty **On the job injury?** Yes / No

Rate Your Pain (0 = No Pain, 10 = Worst Pain You Can Imagine)

Symptoms at Worst: ____ Symptoms at Best: ____ Symptoms Today: ____

How much does pain limit activity? _____ %

Current Medications (include ALL known prescriptions, over the counters, herbals and vitamin/mineral/dietary/nutritional supplements) **____ List Attached**

___Not currently taking any prescribed or over the counter medications, herbals or vitamin/mineral/dietary (nutritional) supplements

Medication / Dose / Frequency / Method	Medication / Dose / Frequency / Method
_____ /_____ /_____ /_____	_____ /_____ /_____ /_____
_____ /_____ /_____ /_____	_____ /_____ /_____ /_____
_____ /_____ /_____ /_____	_____ /_____ /_____ /_____

Past Surgical History

Type of Surgery	Date	Type of Surgery	Date
_____	____/____/ ____	_____	____/____/ ____
_____	____/____/ ____	_____	____/____/ ____

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

___ Chiropractor ___ Practitioner ___ EMG/NCV ___Massage Therapy

___ CT Scan ___ MRI ___ Myelogram ___Neurologist ___ Occupational Therapy

___ Orthopedist ___ Physical Therapy ___ Podiatrist ___ ER ___ X-Rays

Past Medical History: Please check any condition you currently have OR have ever had in the past.

___ Asthma ___ Cancer ___ Diabetes ___Blood Clot ___ Anemia ___Depression

___ Anxiety ___ Gout ___ Seizures ___ Stroke ___ Concussion ___Hernia

___ Fibromyalgia ___ Pacemaker ___Heart Problem ___ Infectious Diseases

___ Sleep Problems ___ Varicose Veins ___ Osteoporosis ___ Visual Dysfunction

___ Migraines/Headache ___ Pins or Metal Implants ___ Neurologic Disorder

___ High Blood Pressure ___ Rheumatoid Arthritis ___ Thyroid Trouble/Goiter

Allergies _____

Patient Medical History

Have you experienced any of these symptoms recently (please check all that apply)

___ Chest Pain ___ Pain with Meals ___ Nausea/Vomiting ___ Dizziness ___ Vision Changes

___ Memory Problems ___Unusual Weakness ___Poor Balance/Falls ___Fever/Chills/Sweats

___ Difficulty Speaking ___ Numbness/Tingling ___Change in Appetite ___Difficulty Swallowing

___ Shortness of Breath ___ Confusion/Brain Fog ___Unusual Pain w/Menstruation

___ Unexplained Weight Loss/Gain ___ Increased Pain at Night/Rest

___Change in Bowel Habits/Control ___Change in Bladder Habits/Control

Other(s) _____

Additional Information

Smoker	Yes	No	If yes, packs per day
Alcohol Use	Yes	No	If yes, drinks per day
Possibly Pregnant	Yes	No	

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 **Printed Name** **Date**