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 _____

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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**