



MEDICAL HISTORY FORM

Please provide us with information regarding your health status and background information.
Your therapist will assist you if there is a question you do not understand. Thank you!

Patient Name: _____

Date: _____

Are you currently:

- Working at your usual job with no restrictions?
- Working at your usual job with restrictions?
- Unable to work because of your condition since: Date: / /
- Unable to work due to other medical reasons?

Are you seeing:

- Primary Care Physician Psychiatrist / Psychologist
- Specialist Chiropractor

Yes No Have you ever had physical therapy for this condition?

Yes No Are you receiving any Home Health Care (Currently or in the past 6 months) ?
If YES, then by what agency? Name: _____ Phone #: _____

If you have seen any of the above during the last three months, please describe reason (illness, injury, routine physical, etc.):

Have you EVER been diagnosed as having any of the following conditions:

Yes	No	Heart problems	Yes	No	Hearing loss / disorder	Yes	No	Circulation problems
Yes	No	High blood pressure	Yes	No	Eye disease	Yes	No	Osteoporosis
Yes	No	Stroke	Yes	No	Muscle disease / disorder	Yes	No	Cancer: If yes, what type:
Yes	No	Rheumatoid Arthritis	Yes	No	Multiple Sclerosis	Yes	No	Past Pregnancy
Yes	No	Other arthritic problem	Yes	No	Diabetes	Yes	No	Currently pregnant?
Yes	No	Lung Disease	Yes	No	Tuberculosis			# of months: _____
Yes	No	Emphysema/Bronchitis	Yes	No	Hepatitis			Other: _____
Yes	No	Asthma	Yes	No	Kidney disease			_____
Yes	No	Chemical Dependency	Yes	No	Thyroid Problems			_____
Yes	No	Epilepsy	Yes	No	Depression			

Please list any surgeries or other conditions for which you have been hospitalized, including dates and reasons:

DATE:	INJURY:	SURGERY:	REASON:

Have you taken any OVER-THE-COUNTER medications in the past week?

Yes	No	Asprin	Yes	No	Decongestants	Yes	No	Vitamins/Mineral Supplements
Yes	No	Advil / Motrin / Ibuprofen	Yes	No	Antacids	Yes	No	Dietary Supplements
Yes	No	Tylenol	Yes	No	Antihistamines			Other: _____

Please list all PRESCRIPTION medications you are currently taking (pills, injections, skin patches, etc...):

Medicine Allergies: _____

Have you recently noted:

Yes	No	Weight loss / gain	Yes	No	Weakness
Yes	No	Nausea / Vomiting	Yes	No	Fever / Chills / Sweats
Yes	No	Fatigue	Yes	No	Numbness or tingling

Signature _____

DATE: _____