Medical History Form

Referring Physician: Date of Birth: Age:	Patient Name:	Today's Date:	Today's Date:		
Date of Next Physician Appointment: Reason for Therapy: Cause of Injury or Onset: Accident Auto Work Other: If Other, please explain: Have you been hospitalized for the present condition? Yes No If Yes, date:	Referring Physician:	Date of Birth:	Date of Birth: Age:		
Reason for Therapy: Cause of Injury or Onset: Accident Auto Work Other: If Other, please explain: Have you been hospitalized for the present condition? Yes No If Yes, date: Did you have surgery for this condition? Yes No If Yes, date: If Yes, surgery lype: Are you currently receiving any other care for the condition mentioned above? Yes No If Yes, date: Have you currently received therapy in the past for the condition mentioned above? Yes No If Yes, date: Describe previous treatment: Successful Unsuccessful Unsuccessful Unsuccessful Unsuccessful Have you fallen in the last year? Yes No If Yes, how many times? If Yes, were you injured? Yes No No No No No No No N	Primary Care Physician: Date of Injury of		nset:		
Cause of Injury or Onset: Accident Auto Work Other: If Other, please explain:	Date of Next Physician Appointment:				
Have you been hospitalized for the present condition? Yes No	Reason for Therapy:				
Have you been hospitalized for the present condition? Yes No	Course of Injury or Opent: Accident	Auto Work Other If Other pleas	e explain.		
Did you have surgery for this condition? Yes No					
If Yes, surgery type: Are you currently receiving any other care for the condition mentioned above? Yes No If Yes, please describe: Have you ever received therapy in the past for the condition mentioned above? Yes No If Yes, date: Describe previous treatment: Previous Treatment: Successful Unsuccessful Have you fallen in the last year? Yes No If Yes, how many times? If Yes, were you injured? Yes No Do you feel unsteady when standing or walking? Yes No Do you worry about falling? Yes No Do you feel unsteady when standing or walking? Yes No Do you worry about falling? Yes No Do You general health: Excellent Good Fair Poor Do you smoke or use tobacco? Yes No DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply) Allergies Latex Other Dizziness Kidney Problems Anemia Epilepsy or Seizure Disorder Metal Implants Anxiety or Panic Disorders Fainting MRSA Arthritis OA RA Fatigue or Weakness Multiple Sclerosis Asthma Fever or Chills Nausea / Vomiting Use of Blood Thinners Fractures Osteoporosis Bleeding Disorder Headaches Pacemaker Bleeding Disorder Headaches Pacemaker Bleeding Disorder Headaches Pacemaker Cancer Hearing Impairment Peripheral Vascular Disease Chronic Cough Heart Disease or Heart Attack Respiratory or Breathing Problem Copp Hepatitis A B C Ringling in Ears Congestive Heart Fallure Hernia Sexual Dysfunction Currently Pregnant Blood Pressure High Low Skin Abnormalities Deep Vein Thrombosis (DVT) HIV or AIDS Thyroid Problems			date:		
Are you currently receiving any other care for the condition mentioned above? Yes No If Yes, please describe: Have you ever received therapy in the past for the condition mentioned above? Yes No If Yes, date: Describe previous treatment: Successful Unsuccessful Unsuccessful Have you fallen in the last year? Yes No If Yes, how many times? If Yes, were you injured? Yes No Do you worry about falling? Yes No No No No No No No N		n? Yes No If Yes, date:			
Have you ever received therapy in the past for the condition mentioned above? Yes No If Yes, date: Describe previous treatment: Previous Treatment: Successful Unsuccessful Have you fallen in the last year? Yes No If Yes, how many times? If Yes, were you injured? Yes No Do you feel unsteady when standing or walking? Yes No Do you worry about falling? Yes No No No you worry about falling? Yes No you worry about falling? Yes No you		care for the condition mentioned above?]Yes □No	er in the state of	
Previous Treatment: Successful Unsuccessful Unsuccessful Have you fallen in the last year? Yes No If Yes, how many times? If Yes, were you injured? Yes No Do you worry about falling? Yes No No No Yes No Yes No No Yes Yes No Yes Yes No Yes Yes Yes Yes No Yes Yes	If Yes, please describe:				
Have you fallen in the last year? Yes No		past for the condition mentioned above?	Yes No If	Yes, date:	
Have you fallen in the last year? Yes No	Describe previous treatment:				
Do you feel unsteady when standing or walking?	The second secon		The state of the s		
Describe your general health:	Have you fallen in the last year? Yoo you feel unsteady when standing	es ☐ No If Yes, how many times? or walking? ☐ Yes ☐ No Do you wo			
DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply) Allergies	What are your personal goals/outcom	es you hope to achieve from therapy?			
DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply) Allergies					
Allergies Latex Other Dizziness Kidney Problems Anemia Epilepsy or Seizure Disorder Metal Implants Anxiety or Panic Disorders Fainting MRSA Arthritis OA RA Fatigue or Weakness Multiple Sclerosis Asthma Fever or Chills Nausea / Vomiting Use of Blood Thinners Fractures Osteoporosis Bowel or Bladder Disorder Headaches Pacemaker Bleeding Disorder Head Injury or Concussion Parkinson's Disease Cancer Hearing Impairment Peripheral Vascular Disease Chronic Cough Heart Disease or Heart Attack Respiratory or Breathing Problem COPD Hepatitis A B C Ringing in Ears Congestive Heart Failure Hernia Sexual Dysfunction Currently Pregnant Blood Pressure High Low Skin Abnormalities Deep Vein Thrombosis (DVT) HIV or AIDS Stroke or TIA Depression Hypoglycemia Thyroid Problems	Describe your general health: Exc	ellent 🗌 Good 🔲 Fair 🔲 Poor 💮 Do yo	u smoke or us	e tobacco? Yes No	
□ Anemia □ Epilepsy or Seizure Disorder □ Metal Implants □ Anxiety or Panic Disorders □ Fainting □ MRSA □ Arthritis □ OA □ RA □ Fatigue or Weakness □ Multiple Sclerosis □ Asthma □ Fever or Chills □ Nausea / Vomiting □ Use of Blood Thinners □ Fractures □ Osteoporosis □ Bowel or Bladder Disorder □ Head Injury or Concussion □ Parkinson's Disease □ Cancer □ Heart Disease or Heart Attack □ Respiratory or Breathing Problem □ Chronic Cough □ Hepatitis □ A □ B □ C □ Ringing in Ears □ Congestive Heart Failure □ Hernia □ Sexual Dysfunction □ Currently Pregnant □ Blood Pressure □ High □ Low □ Skin Abnormalities □ Deep Vein Thrombosis (DVT) □ HIV or AIDS □ Stroke or TIA □ Depression □ Hypoglycemia □ Thyroid Problems	DO YOU CURRENTLY HAVE OR HAVE A	HISTORY OF ANY OF THE FOLLOWING CONDI	TIONS? (check a	all that apply)	
☐ Anxiety or Panic Disorders ☐ Fainting ☐ MRSA ☐ Arthritis ☐ OA ☐ RA ☐ Fatigue or Weakness ☐ Multiple Sclerosis ☐ Asthma ☐ Fever or Chills ☐ Nausea / Vomiting ☐ Use of Blood Thinners ☐ Fractures ☐ Osteoporosis ☐ Bowel or Bladder Disorder ☐ Headaches ☐ Pacemaker ☐ Bleeding Disorder ☐ Head Injury or Concussion ☐ Parkinson's Disease ☐ Cancer ☐ Hearing Impairment ☐ Peripheral Vascular Disease ☐ Chronic Cough ☐ Heart Disease or Heart Attack ☐ Respiratory or Breathing Problem ☐ COPD ☐ Hepatitis ☐ A ☐ B ☐ C ☐ Ringing in Ears ☐ Congestive Heart Failure ☐ Hernia ☐ Sexual Dysfunction ☐ Currently Pregnant ☐ Blood Pressure ☐ High ☐ Low ☐ Skin Abnormalities ☐ Deep Vein Thrombosis (DVT) ☐ HIV or AIDS ☐ Stroke or TIA ☐ Depression ☐ Hypoglycemia ☐ Thyroid Problems	☐ Allergies ☐ Latex ☐ Other	Dizziness	☐ Kidney P	roblems	
□ Arthritis □ OA □ RA □ Fatigue or Weakness □ Multiple Sclerosis □ Asthma □ Fever or Chills □ Nausea / Vomiting □ Use of Blood Thinners □ Fractures □ Osteoporosis □ Bowel or Bladder Disorder □ Headaches □ Parkinson's Disease □ Bleeding Disorder □ Head Injury or Concussion □ Parkinson's Disease □ Cancer □ Hearing Impairment □ Peripheral Vascular Disease □ Chronic Cough □ Heart Disease or Heart Attack □ Respiratory or Breathing Problems □ COPD □ Hepatitis □ A □ B □ C □ Ringing in Ears □ Congestive Heart Failure □ Hernia □ Sexual Dysfunction □ Currently Pregnant □ Blood Pressure □ High □ Low □ Skin Abnormalities □ Deep Vein Thrombosis (DVT) □ HIV or AIDS □ Stroke or TIA □ Depression □ Thyroid Problems	Anemia	☐ Epilepsy or Seizure Disorder	☐ Metal Imp	lants .	
□ Asthma □ Fever or Chills □ Nausea / Vomiting □ Use of Blood Thinners □ Fractures □ Osteoporosis □ Bowel or Bladder Disorder □ Headaches □ Pacemaker □ Bleeding Disorder □ Head Injury or Concussion □ Parkinson's Disease □ Cancer □ Hearing Impairment □ Peripheral Vascular Disease □ Chronic Cough □ Heart Disease or Heart Attack □ Respiratory or Breathing Problem □ COPD □ Hepatitis □ A □ B □ C □ Ringing in Ears □ Congestive Heart Failure □ Hernia □ Sexual Dysfunction □ Currently Pregnant □ Blood Pressure □ High □ Low □ Skin Abnormalities □ Deep Vein Thrombosis (DVT) □ HIV or AIDS □ Stroke or TIA □ Depression □ Hypoglycemia □ Thyroid Problems	☐ Anxiety or Panic Disorders	☐ Fainting	MRSA	to particular his provide	
Use of Blood Thinners ☐ Fractures ☐ Osteoporosis ☐ Bowel or Bladder Disorder ☐ Headaches ☐ Pacemaker ☐ Bleeding Disorder ☐ Head Injury or Concussion ☐ Parkinson's Disease ☐ Cancer ☐ Hearing Impairment ☐ Peripheral Vascular Disease ☐ Chronic Cough ☐ Heart Disease or Heart Attack ☐ Respiratory or Breathing Problems ☐ COPD ☐ Hepatitis ☐ A ☐ B ☐ C ☐ Ringing in Ears ☐ Congestive Heart Failure ☐ Hernia ☐ Sexual Dysfunction ☐ Currently Pregnant ☐ Blood Pressure ☐ High ☐ Low ☐ Skin Abnormalities ☐ Deep Vein Thrombosis (DVT) ☐ HIV or AIDS ☐ Stroke or TIA ☐ Depression ☐ Hypoglycemia ☐ Thyroid Problems	☐ Arthritis ☐ OA ☐ RA	☐ Fatigue or Weakness	☐ Multiple \$	Sclerosis	
□ Bowel or Bladder Disorder □ Head Injury or Concussion □ Pacemaker □ Bleeding Disorder □ Head Injury or Concussion □ Parkinson's Disease □ Cancer □ Hearing Impairment □ Peripheral Vascular Disease □ Chronic Cough □ Heart Disease or Heart Attack □ Respiratory or Breathing Problem □ COPD □ Hepatitis □ A □ B □ C □ Ringing in Ears □ Congestive Heart Failure □ Hernia □ Sexual Dysfunction □ Currently Pregnant □ Blood Pressure □ High □ Low □ Skin Abnormalities □ Deep Vein Thrombosis (DVT) □ HIV or AIDS □ Stroke or TIA □ Depression □ Hypoglycemia □ Thyroid Problems	Asthma	☐ Fever or Chills	☐ Nausea /	Vomiting	
Bleeding Disorder ☐ Head Injury or Concussion ☐ Parkinson's Disease ☐ Cancer ☐ Hearing Impairment ☐ Peripheral Vascular Disease ☐ Chronic Cough ☐ Heart Disease or Heart Attack ☐ Respiratory or Breathing Problem ☐ COPD ☐ Hepatitis ☐ A ☐ B ☐ C ☐ Ringing in Ears ☐ Congestive Heart Failure ☐ Hernia ☐ Sexual Dysfunction ☐ Currently Pregnant ☐ Blood Pressure ☐ High ☐ Low ☐ Skin Abnormalities ☐ Deep Vein Thrombosis (DVT) ☐ HIV or AIDS ☐ Stroke or TIA ☐ Depression ☐ Hypoglycemia ☐ Thyroid Problems	☐ Use of Blood Thinners	☐ Fractures	☐ Osteopor	rosis	
□ Cancer □ Hearing Impairment □ Peripheral Vascular Disease □ Chronic Cough □ Heart Disease or Heart Attack □ Respiratory or Breathing Problem □ COPD □ Hepatitis □ A □ B □ C □ Ringing in Ears □ Congestive Heart Failure □ Hernia □ Sexual Dysfunction □ Currently Pregnant □ Blood Pressure □ High □ Low □ Skin Abnormalities □ Deep Vein Thrombosis (DVT) □ HIV or AIDS □ Stroke or TIA □ Depression □ Hypoglycemia □ Thyroid Problems	☐ Bowel or Bladder Disorder	☐ Headaches	☐ Pacemak	er	
□ Chronic Cough □ Heart Disease or Heart Attack □ Respiratory or Breathing Problem □ COPD □ Hepatitis □ A □ B □ C □ Ringing in Ears □ Congestive Heart Failure □ Hernia □ Sexual Dysfunction □ Currently Pregnant □ Blood Pressure □ High □ Low □ Skin Abnormalities □ Deep Vein Thrombosis (DVT) □ HIV or AIDS □ Stroke or TIA □ Depression □ Hypoglycemia □ Thyroid Problems	☐ Bleeding Disorder	☐ Head Injury or Concussion	☐ Parkinso	n's Disease	
□ COPD □ Hepatitis □ A □ B □ C □ Ringing in Ears □ Congestive Heart Failure □ Hernia □ Sexual Dysfunction □ Currently Pregnant □ Blood Pressure □ High □ Low □ Skin Abnormalities □ Deep Vein Thrombosis (DVT) □ HIV or AIDS □ Stroke or TIA □ Depression □ Hypoglycemia □ Thyroid Problems	Cancer	☐ Hearing Impairment	Peripher	al Vascular Disease	
□ Congestive Heart Failure □ Hernia □ Sexual Dysfunction □ Currently Pregnant □ Blood Pressure □ High □ Low □ Skin Abnormalities □ Deep Vein Thrombosis (DVT) □ HIV or AIDS □ Stroke or TIA □ Depression □ Hypoglycemia □ Thyroid Problems	☐ Chronic Cough	☐ Heart Disease or Heart Attack	Respirate	ory or Breathing Problem	
□ Currently Pregnant □ Blood Pressure □ High □ Low □ Skin Abnormalities □ Deep Vein Thrombosis (DVT) □ HIV or AIDS □ Stroke or TIA □ Depression □ Hypoglycemia □ Thyroid Problems	COPD	☐ Hepatitis ☐ A ☐ B ☐ C	Ringing	in Ears	
□ Deep Vein Thrombosis (DVT) □ HIV or AIDS □ Stroke or TIA □ Depression □ Hypoglycemia □ Thyroid Problems	☐ Congestive Heart Failure	☐ Hernia	☐ Sexual [ysfunction	
□ Deep Vein Thrombosis (DVT) □ HIV or AIDS □ Stroke or TIA □ Depression □ Hypoglycemia □ Thyroid Problems	☐ Currently Pregnant	☐ Blood Pressure ☐ High ☐ Low	☐ Skin Abr	normalities	
☐ Depression ☐ Hypoglycemia ☐ Thyroid Problems ☐		☐ HIV or AIDS	☐ Stroke o	r TIA	
		☐ Hypoglycemia	☐ Thyroid	Problems	
			☐ Tubercu	losis	

Medical History Form

Name of Medication	Dosage Dosage	Frequency	1	
Check Box if Medication List provided separately.		1		
1.			☐ Injection ☐ Oral ☐ Topical ☐ Other	
2.			☐ Injection ☐ Oral ☐ Topical ☐ Other	
3.			☐ Injection ☐ Oral ☐ Topical ☐ Other	
4.	y y was all and		☐ Injection ☐ Oral ☐ Topical ☐ Other	
5.		The state of the s	☐ Injection ☐ Oral ☐ Topical ☐ Other	
6.	***************************************		☐ Injection ☐ Oral ☐ Topical ☐ Other	
7.			☐ Injection ☐ Oral ☐ Topical ☐ Other	
8.	14		☐ Injection ☐ Oral ☐ Topical ☐ Other	
9.	1.100		☐ Injection ☐ Oral ☐ Topical ☐ Other	
10.			☐ Injection ☐ Oral ☐ Topical ☐ Other	
11.	19	35 F 1 12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	☐ Injection ☐ Oral ☐ Topical ☐ Other	
12.			☐ Injection ☐ Oral ☐ Topical ☐ Other	
Over the Counter Medications (check all that apply): Aspiring Cough Medicine Allergy Relief Laxative Diet Pills	n/Ibuprofen ☐ Antac ☐ Vitamins/Herbal S	ids Sleeping Aids upplements Other:	Cold Medicine:	
Pain Scale Rate the severity of your pain by circling a box on the following scale. No Pain Worst Pain 1 2 3 4 5 6 7 8 9 10 On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location. KEY: A = Aching B = Burning N = Numbness P = Tingling S = Stabbing O = Other Signature of Patient:				
Signature of Patient:				
Printed Name of Patient:		Date:		