PATIENT MEDICAL HISTORY

NAME: _____ **AGE:** _____ **DATE OF NEXT DOCTOR'S APPOINTMENT**: _____

I AM PRESENTLY WORKING: LIGHT/MODIFIED DUTY _____ REGULAR DUTY _____ NOT WORKING _____

PROBLEM AREA: HEADACHES ___TMJ ___ NECK ___ UPPER BACK ___ LOW BACK ___ (RIGHT___ OR LEFT___) LEG___ HIP ___

KNEE ___ ANKLE ___ FOOT ___ TOE ___ARM ___ SHOULDER ___ ELBOW ___ WRIST ___ HAND ___ FINGER ___ OTHER: _____

HOW DID THIS PROBLEM BEGIN? LIFTING ___ TWISTING ___ FALLING ___ CRUSHING ___ MOTOR VEHICLE ACCIDENT _____

UNKNOWN ___ OTHER _____ **DATE INJURY OR WHEN PROBLEM FIRST OCCURRED:** _____

WAS THE ONSET GRADUAL ___ OR SUDDEN? ___ **IF YOU HAVE HAD THIS PROBLEM FOR A LONG TIME WHEN DID IT BECOME WORSE?** _____

ARE YOU CURRENTLY BEING SEEN BY ANY OF THE FOLLOWING?

MEDICAL DOCTOR ___ SPEECH THERAPIST ___ DENTIST___ CHIROPRACTOR ___

PHYSICAL/OCCUPATIONAL THERAPIST___ OSTEOPATH ___ PSYCHIATRIST/PSYCHOLOGIST ____

IF YOU HAVE BEEN SEEN BY ANY OF THE ABOVE DURING THE PAST SIX MONTHS, PLEASE DESCRIBE FOR WHAT REASON:

_____

_____

HAVE YOU BEEN HOSPITALIZED FOR THIS PROBLEM? YES ___ NO ___ IF YES, GIVE DATES: _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS FOR THIS CONDITION? IF YES, GIVE DATES: _____

X-RAYS _____ MRI _____ CAT SCAN _____ BONE SCAN _____ BONE DENSITY _____ OTHER _____ NONE _____

PLEASE LIST ANY SURGERIES (IN/OUT PATIENT) AND ANY CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED:

DATE	REASON	DATE	REASON	DATE	REASON

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
____	____	ELEVATED CHOLESTEROL	____	____	RESPIRATORY PROBLEMS	____	____	SEIZURES
____	____	CANCER	____	____	OSTEOPENIA/OSTEOPOROSIS	____	____	DIABETES
____	____	TUBERCULOSIS	____	____	RHEUMATOID ARTHRITIS	____	____	DO YOU SMOKE
____	____	HEPATITIS	____	____	OTHER ARTHRITIC CONDITIONS	____	____	OBESITY
____	____	KIDNEY DISEASE	____	____	CHEMICAL DEPENDENCY	____	____	GI PROBLEMS
____	____	DEPRESSION	____	____	PARKINSON'S DISEASE			
____	____	HIGH BLOOD PRESSURE						
____	____	HISTORY OF HEART DISEASE OR SURGERY? YOU _____ FAMILY _____						
		ARE YOU ACTIVE? _____ INACTIVE? _____						

OTHER CONDITIONS: _____ ALLERGIES-DRUGS/OTHER: _____

ARE YOU PREGNANT? YES __ NO ___

GENERAL: MY HEALTH IN THE LAST MONTH HAS BEEN: EXCELLENT ____ GOOD ____ FAIR ____ POOR ____

COMMENTS: _____

HAVE YOU EVER HAD A FRACTURE OR DISLOCATION? YES ___ NO ___ WHICH BODY PART? _____

DO YOU HAVE ANY OF THE FOLLOWING METALS OR PLASTICS IN YOUR BODY?

RODS ___ PINS ___ PLATES ___ STAPLES ___ SCREWS ___ ARTIFICIAL JOINTS ___ METAL FROM GUNSHOT WOUND ___

PACEMAKER ___ DEFIBULATOR ___ BONE STIMULATOR ___ DIABETIC PUMP ___ NONE _____ LOCATION: _____

CURRENT MEDICATIONS/INJECTIONS: _____

_____

SIGNATURE: _____ **DATE:** _____ RELATIONSHIP TO PATIENT: _____

REVIEWED BY THERAPIST: _____ **DATE:** _____