**Medical History**

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Condition:**

What is the problem you are here for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the date the problem started? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had similar symptoms in the past? ☐ Yes ☐ No If Yes, when? / /

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current work status: ☐Full time ☐Part time ☐Self-employed ☐Retired ☐Off work ☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen anyone else for your current condition (check box/boxes)?

☐Physician/MD ☐Chiropractor ☐Podiatrist ☐Ortho surgeon ☐Massage

☐Dentist ☐Neurologist ☐Physical Therapist ☐Other \_\_\_\_\_\_\_\_\_\_\_\_

Doctor/Therapist/Dentist/Practice Name:

**Past medical History:**

Have you ever had any of the following conditions? Check all that apply.

☐Alcohol use \_\_\_\_\_\_\_\_\_\_\_\_ \_

☐Alzheimer’s / Dementia

☐Asthma

☐Bowel/Bladder problems

☐Cancer History

☐Cardiovascular Disease

☐Cerebral Vascular Accident

☐Current Infection

☐Depression / Anxiety

☐Diabetes Type 1 or Type 2

☐Fainting/dizziness

☐Fall(s) History

☐Fibromyalgia

☐Fracture or Suspected Fracture

☐Headaches

☐Hearing problems

☐Heart condition

☐High blood pressure

☐Lung problems

☐Osteoarthritis

☐Osteopenia

☐Osteoporosis

☐Peripheral neuropathy

☐Rheumatoid arthritis

☐Seizures/epilepsy

☐Stroke

☐Thyroid problems

☐Tobacco use

☐Vision problems

☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any **current Medications** (include over the counter meds) and **Supplements**, please include specific dosages of each medication / supplement. You may provide a list to attach.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Meds / Supplement | Dosage | Frequency | Route | Comments |
|  |  |  | ☐Oral ☐Inject ☐Dermal ☐Rectal |  |
|  |  |  | ☐Oral ☐Inject ☐Dermal ☐Rectal |  |
|  |  |  | ☐Oral ☐Inject ☐Dermal ☐Rectal |  |
|  |  |  | ☐Oral ☐Inject ☐Dermal ☐Rectal |  |
|  |  |  | ☐Oral ☐Inject ☐Dermal ☐Rectal |  |

Please list all surgeries (include approximate date):

|  |  |  |
| --- | --- | --- |
| Type of Surgery | Appx Date | Comment |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

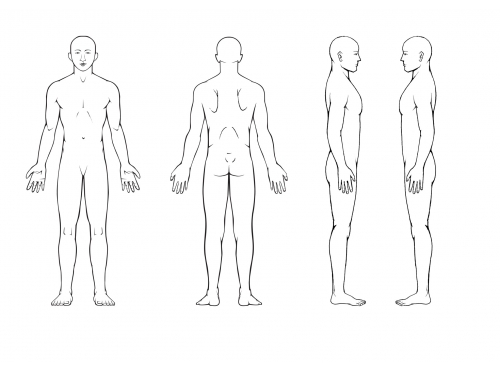
Please list all allergies

|  |  |
| --- | --- |
|  |  |
|  |  |

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please draw/mark where your pain is on the below body diagram (use symbols below to represent your pain).

Numbness - - - - - - Burning xxxxxx Aching ooooooo Stabbing /////////



Rate your pain on the following scale (0 being no pain at all and 10 the worst imaginable pain ever):

Rate what it has been in the last 24 hours.

Worst: 0 1 2 3 4 5 6 7 8 9 10

Current: 0 1 2 3 4 5 6 7 8 9 10

Best: 0 1 2 3 4 5 6 7 8 9 10