Medical History Information

Name: _____ DOB/Age: _____
Referring MD: _____ Family MD: _____
Date of Next MD appt: _____ Occupation: _____
Emergency Contact: _____
(Name) (Phone)

Yes	No	Please circle one. If yes, please explain.
Y	N	History of Heart Attack or Heart/Blood Vessel Problems_____
Y	N	History of Cancer _____
Y	N	History of High/Low Blood Pressure _____
Y	N	History of Stroke or Weakness on one side of body _____
Y	N	Medications (attach list if needed) _____
Y	N	Recent Surgeries or Hospitalizations/Dates_____
Y	N	Recent Tests (x-ray/MRI/CT) _____
Y	N	Breathing Problems _____
Y	N	Diabetes _____
Y	N	Broken Bones (body part/date of injury) _____
Y	N	Osteoporosis _____
Y	N	Arthritis or Joint Problems (Osteo/Rheumatoid/etc.) _____
Y	N	Allergies (latex, cortisone, adhesives) _____
Y	N	Vision or Hearing Problems _____
Y	N	Pins/Metal or Plastic Implants _____
Y	N	Unusual Reaction to Heat or Cold _____
Y	N	Trouble Sleeping/Nightly Hours of Sleep _____
Y	N	Severe or Frequent Headaches _____
Y	N	Require Assistance at Home _____
Y	N	Limitations in Daily Activities _____
Y	N	Anxiety/Depression _____
Y	N	Stomach Disorders (ulcers, etc.) _____
Y	N	Excessive Weight Loss/Gain _____
Y	N	Shingles or Active Skin Rashes _____
Y	N	Loss of Bladder/Bowel Control _____
Y	N	Pelvic Pain (if pregnant, please list due date) _____
Y	N	Do you Smoke _____
Y	N	Tuberculosis/Staph Infections _____
Y	N	Prior Therapies (medical/chiropractor/other): _____

If necessary, please add any other relevant medical information on the back of this page.
Thank you very much for taking the time to inform us about you!

_____ _____
Patient/Guardian Signature/Date Therapist Initials/Date