

# MEDICAL HISTORY FORM

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Check below if you have had any of the following:

Diabetes Mellitus  
 High Blood Pressure  
 Asthma  
 TB  
 Epilepsy  
 Seizures  
 Convulsion

Stroke  
 TIA  
 Cardiac Problems  
 Sinus Problems  
 Hearing Problems  
 Chronic Headaches

Lung Problems  
 Arthritis  
 Pain in Joints  
 Swelling in Joints  
 Fractures  
 Paralysis

Do you wear dentures?  Yes  No

Do you wear glasses?  Yes  No

List any hospitalizations/reasons/dates: \_\_\_\_\_  
\_\_\_\_\_

List any medications you are presently on: \_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medication?  Yes  No

If so, which? \_\_\_\_\_

Do you have a pacemaker?  Yes  No

Do you have any skin allergies?  Yes  No

Do you have any discomfort, shortness of breath, or pain with exercise?  Yes  No

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

Is your occupation:  Active  Inactive  Heavy Work

Are you currently working?  Yes  No

If no, how long have you been off? \_\_\_\_\_

In general, your lifestyle is:      1                      2                      3                      4                      5  
   Active                      Average                      Inactive

Females: Is there a chance that you may be pregnant at this time?  Yes  No

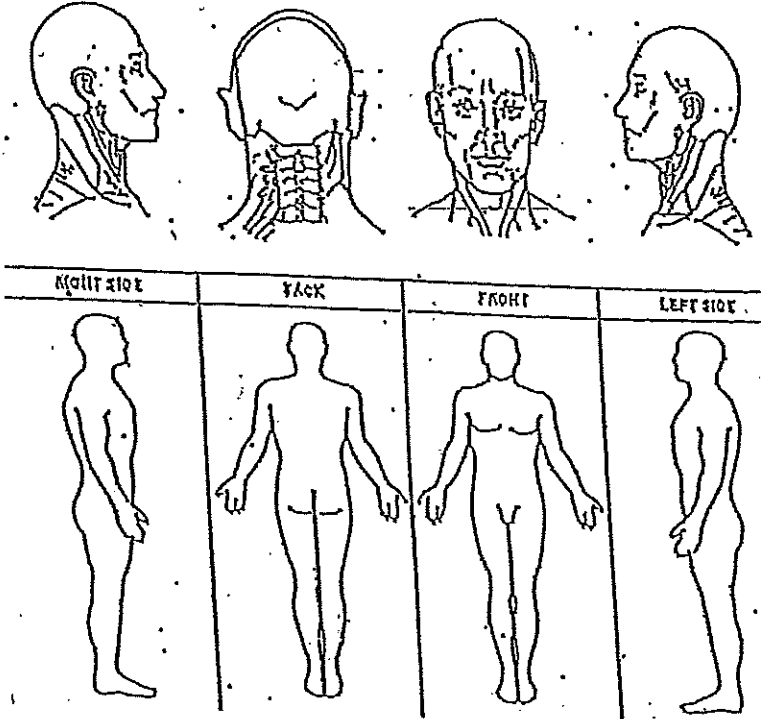
Do you smoke?  Yes  No

How much do you smoke? \_\_\_\_\_ When did you quit? \_\_\_\_\_

What is your primary problem or complaint? (For example: pain, weakness, etc...)  
\_\_\_\_\_

How did your condition develop/begin? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have pain, where is it located? (Mark with an "x" on the diagrams below)



Circle the following to describe your pain: (Ache) (Pressure) (Burning) (Sharp) (Numbness/Tingling)  
 (Throbbing) (Shooting) (Constant) (Occasional) (Morning Pain) (Evening Pain) (Activity Related)  
 Rate your pain: 1 2 3 4 5 6 7 8 9 10  
 No Pain Severe Pain

What position or activity worsens your pain? \_\_\_\_\_

What position or activity eases your pain? \_\_\_\_\_

Is your sleep disturbed?  Yes  No

Circle the following regarding your condition: (Improving) (Worsening) (Staying the Same)

What are you unable to do, what is difficult? \_\_\_\_\_

What do you want to be able to do? \_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

Have you ever received therapy or any other treatment for this condition?  Yes  No

If yes, what type? \_\_\_\_\_

Other comments: \_\_\_\_\_

The signature below indicates that the above information is correct to the best of my knowledge:

Signature \_\_\_\_\_ Date \_\_\_\_\_