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MEDICAL HISTORY FORM

IN ORDER TO COMPLETELY AND SAFELY SERVE YOUR NEEDS WE ASK THAT YOU COMPLETE THIS FORM. THIS QUESTIONAIRE WILL BE KEPT STRICTLY CONFIDENTIAL IN YOUR RECORD / CHART.

Today's date:_____ Name: _____ Age:_____ Male / Female

What areas of the body (e.g. left shoulder, right knee, etc.) are you currently seeking treatment for? Which (if more than one area) is the most problematic at this time?

Have you ever been treated for this same problem before? Where (what clinic)?

Is the current problem you are being seen for the result of a work related injury or motor vehicle accident?
During the past year, have you been treated by any of the following (please circle one)? If so, please elaborate below.

Medical Doctor Chiropractor Surgeon Neurologist Osteopath Psychiatrist/Psychologist Other

Please list all surgeries you have had in the past, including reason and approximate date / year.

Have you ever had cortisone injections? Please state when, how many times and in which part of the body areas.
Do you currently have, or have had HISTORY of: (please circle all that apply or list any not currently listed)

Heart/ Cardiovascular Disease	Asthma/Difficulty Breathing	Hepatitis/Liver Disease	Depression
High Blood Pressure	Congestive heart Failure	Epilepsy/Seizures	Anemia
Diabetes-Type I or II	Multiple Sclerosis	Thyroid Condition	Stroke
Osteoporosis /Fractures	Fibromyaliga	Neurological Condition	Lupus
Chronic Infections	Rheumatiod Arthritis	Migraines/Headaches	Osteoarthritis
Eating Disorders	Kidney/Renal Disease	Hearing Problems	

Vestibular disorder/Dizzy/Fainting Spells Drug/Alcohol Abuse Smoking/Tobacco Use
Circulatory Disorder / Poor Circulation Other_____
Cancer_____Location_____ Year_____

Do you have a pacemaker, internal defibrillator, insulin pump, or any other implanted medical devices?

Please list all prescription medication you are presently taking and reason for medication (i.e. Accupril for Blood Pressure, Prozac for Depression).

Are you currently, or is there any chance you may be pregnant? YES NO N/A

Have you ever had any difficulties or loss of control with bowel and/or bladder functioning?

Do you exercise regularly? How often and what activities? Do you play any sports?

I CERTIFY TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE AND TRUE.

Signature (parent of guardian of under 18 years of age) Today's date