PATIENT MEDICAL HISTORY FORM

Name: _____ Treating Physician_____

Primary Care Physician: _____ Date of 1st Doctors Visit for this injury_____

Last Day worked Due to this Injury (if applicable): _____

Date Returned to Work after Injury (if applicable): _____

Have you retained an attorney as a result of your injury? YES NO

Referral Source: Surgeon Rehab MD Other: _____

Have you had Surgery for this Injury? YES NO Number of Surgeries: _____

Type of Surgery(ies): _____

Have you had any of the following diagnostic, medical or rehabilitative services for the injury/episode?

	YES	NO		YES	NO
Chiropractor	___	___	General Practitioner	___	___
EMG/NCV	___	___	CT scan	___	___
Massage Therapy	___	___	MRI	___	___
Myelogram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room	___	___	X-Rays	___	___

Do you now or have you ever had any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	___	___	High Blood Pressure	___	___
Anemia	___	___	Shortness of Breath/Chest Pain	___	___
Heart Attack or Surgery	___	___	Diabetes	___	___
Coronary Heart Disease or Angina	___	___	Thyroid Trouble/ Goiter	___	___
Gout	___	___	Cancer/Chemo/Radiation	___	___
Dizziness or Fainting	___	___	Weakness	___	___
Emotional/Psychological Problems	___	___	Infectious Diseases	___	___
Hernia	___	___	Bowel or Bladder Problems	___	___
Numbness or Tingling	___	___	Allergies	___	___
Severe or Frequent Headaches	___	___	Elbow/Hand Injury	___	___
Osteoporosis	___	___	Vision or Hearing Difficulties	___	___

	YES	NO		YES	NO
Neck Injury/ Surgery	___	___	Stroke/TIA	___	___
Sleeping Problems/Difficulties	___	___	Back Injury/Surgery	___	___
Blood Clot/Emboli	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Knee Injury/Surgery	___	___	Epilepsy/Seizures	___	___
Do you have a Pacemaker?	___	___	Arthritis/Swollen Joints	___	___
Varicose Veins	___	___	Any Pins or Metal Implants?	___	___
Are You Pregnant?	___	___	Joint Replacement	___	___
Weight Loss/ Energy Loss	___	___	Bowel or Bladder Problems	___	___
Do you smoke?	___	___			

Please list any additional information that would assist us in providing care to you?

_____

_____

Are you aware of your diagnosis (what you are being treated for at our clinic)? Yes No

What are your expectations/goals?

_____

_____

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Patient/Legal Guardian Signature: _____Date: _____

Patient/Legal Guardian Name: _____

Therapist's Signature: _____Date: _____

FOR THERAPIST USE ONLY:

Height: _____ Weight: _____ BMI: _____