Patient Medical History

Patient Name: _____ **Condition Begin Date** ____ / ____ / _____

Work Status: Full Time / Part Time / Off Duty **On the job injury?** ☐ Yes / No ☐

Rate Your Pain (0 = No Pain, 10 = Worst Pain You Can Imagine)

Symptoms at Worst: ____ Symptoms at Best: ____ Symptoms Today: ____

How much does pain limit activity? _____ %

Current Medications (include ALL known prescriptions, over the counters, herbals and vitamin/mineral/dietary/nutritional supplements) **____ List Attached**

___Not currently taking any prescribed or over the counter medications, herbals or vitamin/mineral/dietary (nutritional) supplements

Medication / Dose / Frequency / Method	Medication / Dose / Frequency / Method
_____ /_____ /_____ /_____	_____ /_____ /_____ /_____
_____ /_____ /_____ /_____	_____ /_____ /_____ /_____
_____ /_____ /_____ /_____	_____ /_____ /_____ /_____

Past Surgical History

Type of Surgery	Date	Type of Surgery	Date
_____	____/____/ ____	_____	____/____/ ____
_____	____/____/ ____	_____	____/____/ ____

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

☐ Chiropractor ☐ Practitioner ☐ EMG/NCV ☐ Massage Therapy
☐ CT Scan ☐ MRI ☐ Myelogram ☐ Neurologist ☐ Occupational Therapy
☐ Orthopedist ☐ Physical Therapy ☐ Podiatrist ☐ ER ☐ X-Rays

Past Medical History: Please check any condition you currently have OR have ever had in the past.

☐ Asthma ☐ Cancer ☐ Diabetes ☐ Blood Clot ☐ Anemia ☐ Depression
☐ Anxiety ☐ Gout ☐ Seizures ☐ Stroke ☐ Concussion ☐ Hernia
☐ Fibromyalgia ☐ Pacemaker ☐ Heart Problem ☐ Infectious Diseases
☐ Sleep Problems ☐ Varicose Veins ☐ Osteoporosis ☐ Visual Dysfunction
☐ Migraines/Headache ☐ Pins or Metal Implants ☐ Neurologic Disorder
☐ High Blood Pressure ☐ Rheumatoid Arthritis ☐ Thyroid Trouble/Goiter

Allergies _____

Patient Medical History

Have you experienced any of these symptoms recently (please check all that apply)

☐ Chest Pain ☐ Pain with Meals ☐ Nausea/Vomiting ☐ Dizziness ☐ Vision Changes

☐ Memory Problems ☐ Unusual Weakness ☐ Poor Balance/Falls ☐ Fever/Chills/Sweats

☐ Difficulty Speaking ☐ Numbness/Tingling ☐ Change in Appetite ☐ Difficulty Swallowing

☐ Shortness of Breath ☐ Confusion/Brain Fog ☐ Unusual Pain w/Menstruation

☐ Unexplained Weight Loss/Gain ☐ Increased Pain at Night/Rest

☐ Change in Bowel Habits/Control ☐ Change in Bladder Habits/Control

Other(s) _____

Additional Information

Smoker	☐ Yes	☐ No	If yes, packs per day
Alcohol Use	☐ Yes	☐ No	If yes, drinks per day
Possibly Pregnant	☐ Yes	☐ No	

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 **Printed Name** **Date**