MEDICAL HISTORY

Name:_________________________ Date:___________________ Age:_______ DOB:_____________

Emergency Contact: Name __________________________ Phone Number _____________________________

Do you Smoke: YES NO Referring Physician: _____________ Work Status: _______

Date of Onset Injury/Complaint:__________ Do you live with someone? Spouse/Children/Caretaker/Other

Briefly describe your injury and/or complaint:____

Prior to your injury/complaint, were you limited in your daily activities? **YES NO**

If "YES", please list specific past limitations: ____

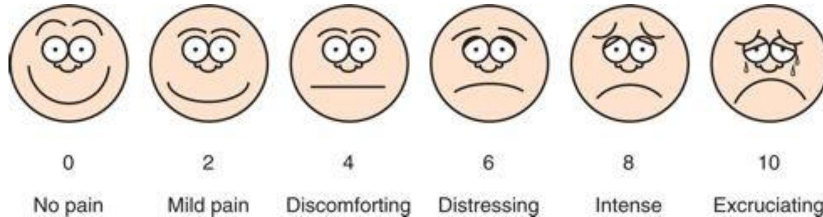
Please list your hobbies/recreational activities: ____

Nature of pain/symptoms (if applicable): sharp aching intermittent constant dull throbbing

Since the onset, are your symptoms getting: better | worse | no change

As your day progresses, do your symptoms: increase decrease stay the same no pattern

Pain Levels (if any): Current level________Worst ____________ Least_____________



Personal Medical History: Please circle all that apply:

Cancer	Heart Conditions	Arthritis	Osteoporosis	Depression	Stroke/TIA
Fractures	Balance/Falls	Bladder problems	Diabetes	Thyroid problems	
Head Injury	Epilepsy/Seizures	Parkinson's	Fibromyalgia	Multiple Sclerosis	
Skin Disease	Stomach Problems	Circulation	High Blood Pressure		
Rheumatoid Arthritis		Infections	Allergies	Other: _________________	

Medications (disregard if a copy was given to the front desk): ____

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Patient/Guardian Signature: ______________________________Date: ________________________