Medical History

Name: _____ **Date**:_____

When is your next appointment with your referring physician? ____/____/_____

Have you had surgery related to this injury? Y☐/ N☐ Date ____/ ____ / ____

Do you have a primary care physician Y☐/ N☐

If Yes, have you had an appointment with them in the past 12 months? Y☐/ N☐

Height: _____ft _____inch Weight: _____lbs Are you presently working? Y☐/ N☐

Anything else we should know about your health? _____

_____

_____

Please Mark **One** Box for each item	No	Yes (for less than 12 mos)	Yes (for more than 12 mos)	Please Mark **One** Box for each item	No	Yes (for less than 12 mos)	Yes (for more than 12 mos)
Smoking				Are you Pregnant?			
Diabetes				Sexual dysfunction			
Heart Condition				Bladder/Bowel problems			
High Blood Pressure				Groin Numbness			
Chest Pain				Arthritis			
Stroke				Osteoporosis			
Kidney Disease				Psychological Condition			
Blood clot/DVT				Seizures			
Metal Implants/Pace maker				Dizziness/Faintness			
Breathing difficulties/asthma				Ringing in Ears			
Cancer				Latex Allergy			
Difficulty swallowing				Other Allergy			
Unexplained weight loss				Fractures			
Double Vision				Active Infection			
Night sweats/night pain				Fever/Nausea			
Hepatitis/HIV				Other			
Previous injury to current body-part being treated				Falling (with injury) in last 12 months			

Please provide further detail for any "Yes" answers above: _____

_____

_____

Current Medications: _____

_____

_____

I confirm the above information is accurate to the best of my knowledge. **Initials** _____