

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