Medical History

Name: _____ **Age:** _____ **Date:** _____

About your current condition…

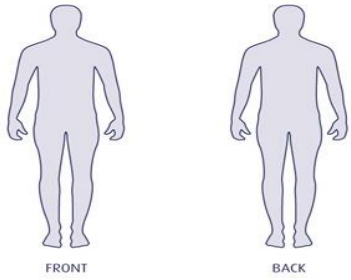
What is the condition that brought you here today? _____
When did your condition begin or get worse? _____
What caused your condition? _____

Please circle your ability to perform daily activities… **0% unable** **25%** **50%** **75%** **100% easy**

What makes your condition feel better? _____
What makes your condition feel worse? _____
Please circle the symptoms that apply to your condition…
Dull Throbbing Tingling Radiating Shooting Aching Burning Stabbing Numbness

How frequent are your pain symptoms? **Constant/Intermittent**
How long does the pain last? _____
How much pain are you experiencing right now? (0-10 scale) _____
Please circle the tests that you have had for this condition…
None X-Ray CAT Scan MRI Myelogram Bone Scan
Results: _____
Please circle the treatment that you have had for this condition…
PT OT ATC Chiropractor Alt. Medicine Other
Have you had surgery for this condition? _____
Date and Type of surgery? _____
What is your occupation and current work status? _____

(Circle area of pain on diagram)



About your general health…

Please circle all medical conditions that you have or have had in the past…

Osteoarthritis	**Osteoporosis**	**Rheumatoid Arthritis**	**Pregnancy**
Nausea	**High Blood Pressure**	**Joint Replacement**	**Metal Implants**
Headaches	**Cancer**	**Epilepsy**	**Pacemaker**
Fainting	**Diabetes**	**Asthma**	**Fatigue**
Allergies	**Bowel Dysfunction**	**Weight Change**	**Shortness of Breath**
Dizziness	**Smoker**	**Substance Abuse**	**Other**

Please list other surgeries that you have had: _____
Please list any known allergies: _____
Please list any medications you are taking for this condition: _____

What is your goal with therapy treatment for this condition? _____

_____

Is there anything else that we need to know about your condition? _____

_____

Patient Signature: _____ **Date:** _____