PATIENT MEDICAL HISTORY

Name _____ Date of this injury/episode _____
Referring Physician: _____ Family Physician _____
Who referred you to us _____ Occupation _____
Last date worked due to this injury _____ Returned to work _____
Have you had surgery for THIS condition? YES NO Surgeon _____
List surgery/ies & dates _____
Please list prescription or non-prescription medications you are taking.
_____ Pain medication _____
_____ Anti-inflammatory _____
_____ Muscle relaxers _____

Have you had any of the following services/tests for THIS injury/episode/surgery?

Physical therapy	YES	NO	Neurosurgeon	YES	NO
Massage therapy	YES	NO	Podiatrist	YES	NO
Occupational therapy	YES	NO	X-Ray	YES	NO
Chiropractic	YES	NO	MRI	YES	NO
General Practitioner	YES	NO	CT Scan	YES	NO
Emergency Room Care	YES	NO	Bone Scan	YES	NO
Orthopedist	YES	NO	EMG/NCV	YES	NO
Neurologist	YES	NO	Other _____		

CIRCLE ALL THAT APPLY:

Cancer:Location_____ Date_____
Shortness of breath/chest pain
Do you have a Pacemaker
High blood pressure
Heart attack
Heart surgery
Stroke/TIA
Blood clot/emboli
Epilepsy/seizures
Thyroid disease/ surgery
Anemia
Diabetes
Rheumatoid arthritis
Osteoporosis
Hemophilia
Hepatitis
HIV

Severe or frequent headaches
Pain sleeping
Numbness / tingling
Dizziness / fainting
Weight loss/energy loss
Hernia
Vericose veins
Allergies: list_____
Any pins or metal implants:list_____
Joint replacement(s):list_____
Neck injury/surgery
Shoulder injury/surgery
Elbow/hand injury/surgery
Back injury/surgery
Knee injury/surgery
Ankle injury/surgery
Do you smoke? / How much?_____

List any other medical information or condition not listed above: _____

What are your expectations/goals while in this program _____
_____

Patient/Guardian Signature_____ Date _____