Medical History

Date:_____ **Name:** _____

DOB:_____ **Age:**_____ **Height:** _____’_____’’ **Weight**: _____ lbs.

I am here today because: _____

Date of Injury/Onset:_____ **Cause:** ☐ Auto ☐ Work ☐ Sports ☐ Unknown ☐ Other _____

Relevant Surgery Date(if applicable):_____ **Describe:**_____

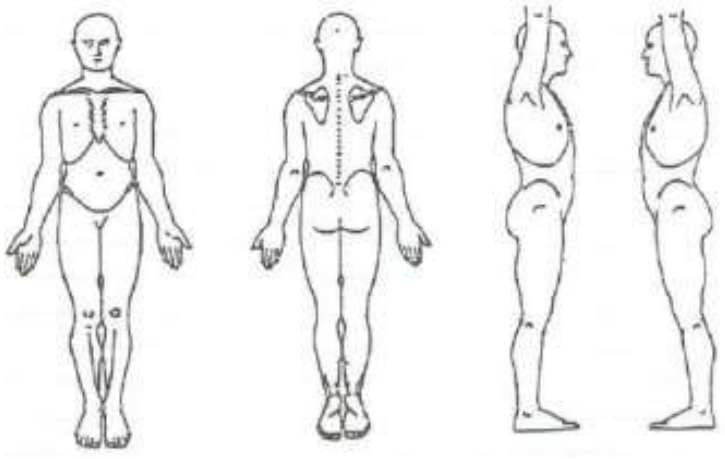
Other Surgical History: _____

Current Meds (if medicare fill out separate med list): _____

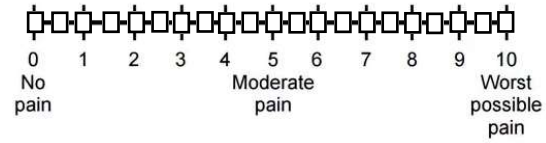
Relevant X-Rays: _____ **CT–Scan:** _____ **MRI:** _____ **Other:** _____

USING THE DIAGAM INDICATE WHERE YOU ARE EXPERIENCING SYMPTOMS

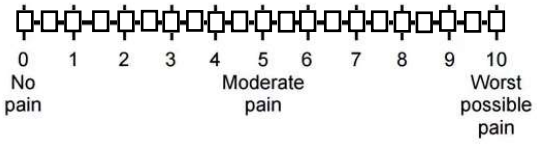
XXX = Pain ///// = Numbness/Tingling



AVERAGE PAIN INTESITY: Past week



WORST PAIN INTENSITY: Past week



How often do you experience symptoms:

☐ Constantly: (76 -100% of the time)
☐ Frequently: (51-75% of the time)
☐ Occasionally: (26-50% of the time)
☐ Intermittently: (0-25% of the time)

How much have your symptoms interfered with your usual daily activities?

☐Not at all ☐ A little bit ☐Moderately ☐Quite a bit ☐ Extremely

Please select or describe any prior treatments or self-care for this condition:

☐Chiropractic ☐Heat ☐Cold ☐Exercise ☐Physical Therapy ☐Injections
☐Other_____

Please select or describe what you want to accomplish from therapy (Your Goals/Limitations):

☐Improve sleep ☐Decrease pain ☐Sitting/Standing ☐Reaching/Lifting ☐ Recreation
☐Stairs ☐ Walking ☐Other _____

Are you currently working? ☐Yes ☐No **Restrictions?** ☐Yes ☐No
Employer _____ **Hours/Week:** _____

Medical History

Please check the box next to any of the following you experience,
if you have been diagnosed with the condition, or if the symptom/status applies to you.

General Health:

- ☐ Current Smoker
- ☐ Pregnant (or potentially)
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Respiratory Problems
- ☐ Asthma
- ☐ Hepatitis
- ☐ Seizures
- ☐ Osteoporosis
- ☐ Kidney Problems
- ☐ Stroke
- ☐ Concussion
- ☐ Depression
- ☐ Thyroid Problems
- ☐ Arthritis
- ☐ Blood Clots
- ☐ Pacemaker
- ☐ Metal Implants
- ☐ Circulation Problems
- ☐ Stomach Ulcers
- ☐ Recent Nausea/Vomiting
- ☐ Hearing Problems/Loss
- ☐ Infectious Diseases (HIV, Hepatitis, TB, etc…) _____
- ☐ Other: _____

Head/Jaw/Neck:

- ☐ Facial Pain
- ☐ Experience a click or pop when you open or close your mouth
- ☐ Weekly headaches
- ☐ Pain in the front of your ear
- ☐ Ear "fullness" or "ringing"
- ☐ Wake up with a dry mouth
- ☐ Tension at the base of your skull when you turn your head in the upright position
- ☐ Previous braces, retainers, or dentures
  if so, when? _____
- ☐ Currently wear mouth appliance or retainer

Breathing:

- ☐ Snoring
- ☐ Diagnosed with sleep apnea
  - ☐ Use CPAP or Mouth Splint
- ☐ Difficulty breathing with simple activities (i.e. going up steps)
- ☐ Feel tired after a full night of sleep
- ☐ Use an inhaler
- ☐ Have to sleep upright

Feet:

- ☐ Flat Feet
- ☐ Pain on the bottom of your feet when you are standing
- ☐ Large bony bump near either of your big toes
- ☐ Use orthotics/heel lifts/other foot inserts in shoes
- ☐ One foot turns out more than the other
- ☐ Feel unstable with one or both ankles
- ☐ 1 or more ankle sprains
  - ☐ Right ankle ☐ Left ankle

Vision:

- ☐ Wear contacts
- ☐ Wear glasses
- ☐ Wear bifocals/progressive lenses
- ☐ Occasionally bump into objects while walking
- ☐ Difficulty driving at night
- ☐ Blurry/double vision
- ☐ Dizziness
- ☐ Have astigmatism
- ☐ History of lazy eye
- ☐ Lasik surgery,
  if so, when? _____

Lumbo/Pelvic/Femoral:

- ☐ Small amounts of urine leakage with coughing, sneezing, laughing, lifting, or exercising
- ☐ Small amounts of urine leakage associated with a strong sensation of needing to go to the bathroom
- ☐ Frequent trips to the bathroom that disrupt your day or needing to plan trips out based on where the bathrooms are
- ☐ Frequently strain to have a bowel movement or empty your bladder
- ☐ Pain, discomfort, or pressure in the pelvic area when sitting or standing of prolonged periods of time

List any other issues/concerns you would like us to know about: _____

_____

_____

_____

_____

Current Medication List

(Medicare Patients Only)

Patient Name: _____ DOB:_____ Date: _____

please list all tablets, patches, drops, ointments, injections, etc.. In addition, include prescription, over-the-counter, herbal, vitamin, and diet supplement products and anything that you take only on occasion (like albuterol, nitroglycerin, etc…)

Medication Name	Reason for Taking	Dosage	# of Time(s) of Day/When	Form (tablet, cap, etc…)