

Medical History Form

Diagnosis as stated to you by your physician: _____ Date of onset: _____

How did this injury/exacerbation occur: _____

Have you been hospitalized for the present condition? Yes No If Yes, date: _____

Have you had surgery for the present condition? Yes No If Yes, date: _____

Have you received previous treatment for this condition? Yes No If Yes, date: _____

If yes, please summarize: _____

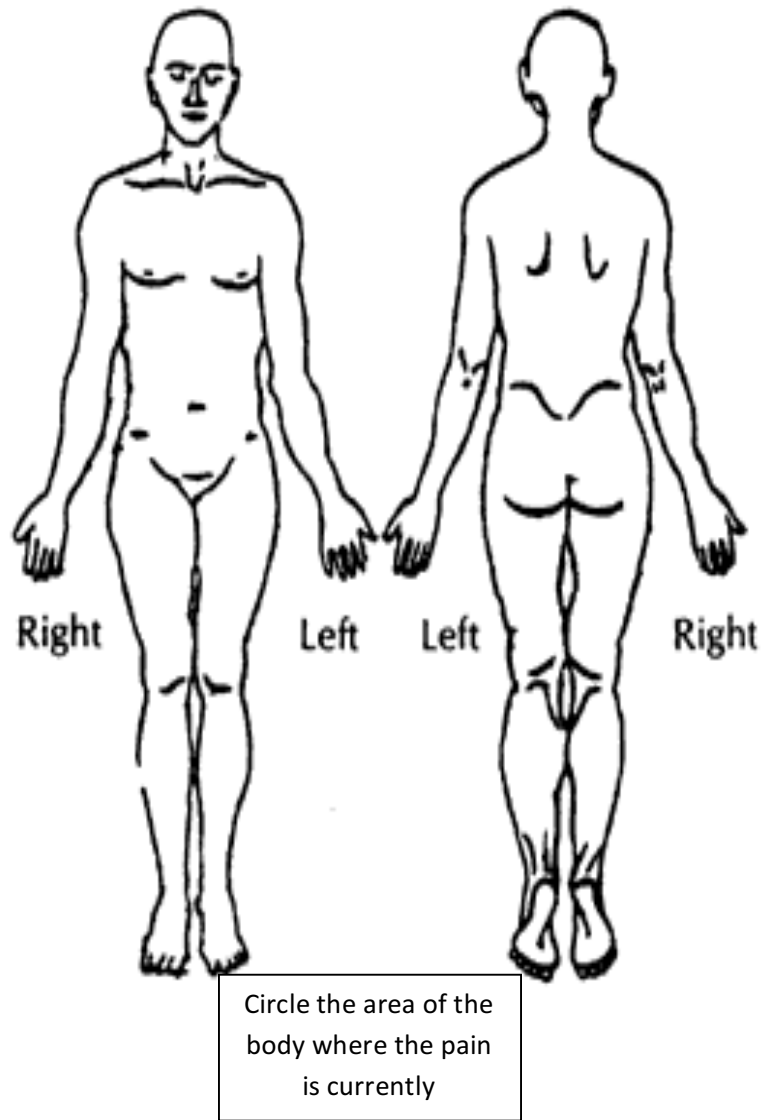
Are you currently receiving or have you received in the last 30 days any home health, medical or chiropractic services rendered to you by any other agency, organization or individual? If you, please summarize:

Are you on any medications? Please list (you may use reverse side):

Have you ever had any of the following for the present condition: MRI CT SCAN X-RAY

Have you ever, or are you presently being treated for any of the following conditions?

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ringling in your ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respiratory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis A, B, C	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea/Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Surgeries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
List w/dates:		



Please circle all that may apply. My pain is worse:

In the morning / during the day / at night / constant / with or during activity

On a scale of 0 to 10, (0 being no pain and 10 being unbearable pain requiring hospitalization) please rate your pain:

/10 least pain

/10 worst pain