**Patient Medical History**

Name_______________________________________ Date of Birth______/______/______ Age_________

Referring Physician___________________________ Family Physician______________________________

**Medicare Only: Height____________ Weight____________**

Date of Injury______/______/______ Have you had surgery for this injury? Yes No

Are you currently taking any medications?

| | | |
|---|---|---|
| Prescription | Yes | No |
| Over the Counter | Yes | No |
| Other | Yes | No |

If YES to any questions above, please fill out: (Write on back if additional space is needed)

Medication Name______________________ Dosage__________ Frequency __________Route__________

Medication Name______________________ Dosage__________ Frequency __________Route__________

Are you allergic to any Medications, Latex, or Tape? Yes No
If YES, please list____________________________________________________________________________

Have you ever had any of the following Medical or Rehab services for **this injury**?

| | YES/NO |
|---|---|
| Chiropractor | ____l____ |
| CT Scan | ____l____ |
| EMG/NCV | ____l____ |
| MRI | ____l____ |
| X-Rays | ____l____ |
| Physical Therapy | ____l____ |

Other__________________________________________________________________________________________

Do you have or have had **ANY** of the following?

| | | | |
|---|---|---|---|
| Shortness of breath/Chest Pain | Y N | Gout | Y N |
| Coronary Heart Disease | Y N | Hernia | Y N |
| Pacemaker | Y N | Osteoporosis | Y N |
| High Blood Pressure | Y N | Headaches | Y N |
| Heart Attack or Heart surgery | Y N | Vision/Hearing Difficulties | Y N |
| Stroke/TIA | Y N | Numbness/Tingling | Y N |
| Emboli Blood Clot | Y N | Dizziness/Fainting | Y N |
| Epilepsy/Seizures | Y N | Weakness | Y N |
| Anemia | Y N | Weight Loss/Energy Loss | Y N |
| Joint Replacement Surgery | Y N | Varicose Veins | Y N |
| Infectious Disease | Y N | Any Pins or Metal Implants | Y N |
| Diabetes | Y N | Allergies | Y N |
| Arthritis | Y N | Are you pregnant? | Y N |
| Cancer/Chemotherapy/Radiation | Y N | | |

Please list any other information pertaining to your current injury that would assist us in your care.

---

Are you aware of your diagnosis and prognosis as explained by your doctor? YES NO

How did you hear about us? ______________________________________________________________

Based on your awareness, what are your rehabilitation goals/expectations while in treatment?

---

**Patient/GuardianSignature_____________________________________________________**