Medical History Questionnaire

Name:	Date of Birth Age
Reason for Therapy:	
Date of Injury or Onset:	
Are you currently receiving any other care for the this condition? Yes No If yes, where?	
Have you ever received therapy in the past for this condition? Yes No If so, when?	
Previous Treatment Received:	Was this treatment successful? Yes No
Have you received physical therapy services for any other reason during the current year? Yes No If yes, please list reason and location:	
Have you ever been or are you currently seeing a Chiropractor? Yes No	
Could you be or are you pregnant? Y N	

Do you now, or have you ever had any of the following conditions?

Arthritis	Y	N	Diabetes	Y	N	Numbness/Tingling	Y	N
Osteoporosis	Y	N	Anemia	Y	N	Fever / Chills	Y	N
High Blood Pressure	Y	N	Swelling in ankles	Y	N	Thyroid Problems	Y	N
Heart Disease	Y	N	Deep Vein Thrombosis	Y	N	Headaches	Y	N
Heart Attack	Y	N	Seizure/Epilepsy	Y	N	Head injury / Concussion	Y	N
Pacemaker	Y	N	Metal in body	Y	N	Dizziness/Light Headedness	Y	N
Vascular Disease	Y	N	Surgical implants	Y	N	Kidney / Bladder Problems	Y	N
Stroke	Y	N	Cancer/tumor	Y	N	Previous Fractures	Y	N
Asthma	Y	N	Recent weight gain/loss	Y	N	Previous Surgeries	Y	N
Shortness of breath	Y	N	Fatigue/Weakness	Y	N	Hearing Loss	Y	N
History of Falls	Y	N	Tuberculosis	Y	N	Depression	Y	N
Hernia	Y	N	Recurrent infections	Y	N	Anxiety	Y	N
Fainting Spells	Y	N	Infection in last 3 months	Y	N	Substance Abuse	Y	N
Nausea / Vomiting	Y	N	Hepatitis	Y	N	Hypersensitive to Heat/Cold	Y	N

If you answered "Yes" to any of the above or have another condition not listed, please explain and give approximate dates:

Do you have any allergies? Yes No If Yes, please list: :

Are you presently taking any medications? Yes No If Yes, please list:

At the present time would you say that your health is (circle one); Excellent Very Good Fair Poor

The information is correct to the best of my knowledge:

X _____ Date: _____

Patient/Parent/Guardian Signature