MEDICAL HISTORY FORM

PATIENT NAME: _____ . _____ . _____ DOB: _____ DATE: 2/18/2021
First Last MI

Area(s) for which you're receiving therapy_____

Date of Injury (if any)_____ Approximate Date of Onset (if no injury)_____

Check which apply to your current condition:

☐ Work related injury ☐ Recurrence of previous injury ☐ Injury related to falling
☐ Motor vehicle accident ☐ Injury related to lifting
☐ Cause unknown ☐ Athletic/recreational injury ☐ Other: _____

Have you had treatment for this area before? ☐Yes ☐ No If yes, date last treated_____

Describe type of treatment_____

Have you had surgery for this area? ☐ Yes ☐ No If yes, date of most recent surgery_____

Type of Surgery_____

List any diagnostic testing you have had for this area: ☐ X-ray ☐ MRI ☐ CT scan ☐ EMG

Past Surgical History (type and date):_____

List any allergies (latex, drug, etc.):_____

Are you pregnant? ☐Yes ☐No ☐ N/A If "Yes", please list your due date:_____

Do you have or have you ever had any of the following?

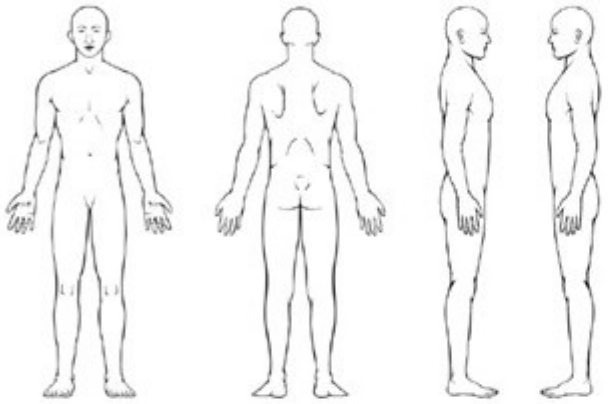
	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
High Blood Pressure	☐	☐	Allergies to Heat	☐	☐
Heart Disease	☐	☐	Allergies/Poor Tolerance to Cold	☐	☐
Heart Attack	☐	☐	Other Allergies	☐	☐
Heart Palpitations	☐	☐	Hernia	☐	☐
Pacemaker	☐	☐	Seizures	☐	☐
Headaches	☐	☐	Metal Implants	☐	☐
Kidney Problems	☐	☐	Dizziness/Fainting	☐	☐
Cancer	☐	☐	Recent Fractures	☐	☐
Osteoporosis	☐	☐	Skin Abnormalities	☐	☐
Bowel/Bladder Abnormalities	☐	☐	Nausea/Vomiting	☐	☐
Urine leakage	☐	☐	Ringing in your ears	☐	☐
Asthma/Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver/Gall bladder problems	☐	☐	Stroke/CVA	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Other:_____	☐	☐	Depression/Anxiety	☐	☐

Any other conditions not listed above_____

PATIENT NAME: _____ . . _____ DOB: _____ DATE: 2/18/2021

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition

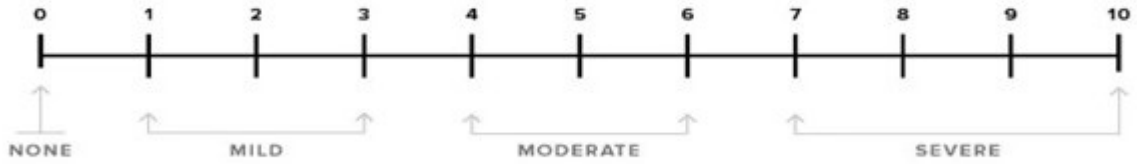


Key

↑ or ↓ Radiating Pain
XXX Spasm
ZZZ Tenderness
//// Numbness/Tingling
000 Ache/Pain

Please rate your pain number using the scale below: At this moment_____ At its best_____ At its worst_____

0-10 NUMERIC PAIN RATING SCALE



Please circle any symptoms you are currently experiencing:

Unexplained weight loss	Numbness/tingling	Changes in appetite	Fevers/chills/sweats
Depression	Shortness of breath	Dizziness	Headaches
Changes in bowel/bladder	Nausea/Vomiting	Poor balance/falls	Increased pain at night

Are your symptoms currently (circle one): Getting better / About the same / Getting worse

What are your personal goals for therapy at this time:_____

_____

To the best of my knowledge, the above information is true and correct.

Patient or Patient Representative's Signature:_____ Date:_____