Medical History

Name: ____ *Date of Birth:* ______________________

Date: _______________________ *Referring Physician:* _______________________________________

Do you have any medication or environmental allergies? *Yes* ☐ *No* ☐

Please list allergies: ____

Are you currently taking any medication? (Prescription or over the counter): *Yes* ☐ *No* ☐

Please list medications: ____

____

Height: _______'_______ *Weight:* ____________ *Falls in the past year?* *Yes* ☐ *No* ☐

Please check if you have you ever had any of the following:

	Yes	No		Yes	No
Diabetes	___	___	Epilepsy/seizures	___	___
Vision or hearing difficulties	___	___	Anemia	___	___
Dizziness/fainting	___	___	Thyroid disease	___	___
Numbness/tingling	___	___	Infectious diseases	___	___
Weakness	___	___	Frequent Headaches/Migraines	___	___
Shortness of breath	___	___	Cancer/chemotherapy/radiation	___	___
Unexplained weight loss/gain	___	___	Arthritis	___	___
Bowel or bladder problems	___	___	Osteoporosis	___	___
Hernia	___	___	Sleeping problems	___	___
Varicose veins	___	___	Psychological problems	___	___
Are you pregnant?	___	___	Do you have a pacemaker?	___	___
Do you use any tobacco products?	___	___	Any pins/metal implants	___	___
Asthma/bronchitis/ emphysema	___	___	Joint replacement surgery	___	___
Coronary heart disease	___	___	Neck injury/surgery	___	___
Angina/chest pain	___	___	Shoulder injury/surgery	___	___
High blood pressure	___	___	Hand/elbow injury/surgery	___	___
Heart attack/heart surgery	___	___	Back injury/surgery	___	___
Stroke/TIA	___	___	Knee injury/surgery	___	___
Blood Clot	___	___	Leg injury/surgery	___	___
Gout	___	___	Ankle/foot injury or surgery	___	___

Any other medical concerns we should be aware of? ____

____

Please check you had any medical/rehabilitative services for this injury:

	Yes	No		Yes	No
X-ray	___	___	Chiropractor	___	___
CT scan	___	___	Occupational therapy	___	___
MRI	___	___	Physical therapy	___	___
EMG/NCV	___	___	General practitioner	___	___
Myelogram	___	___	Neurologist	___	___
Emergency room	___	___	Orthopedist	___	___
Massage therapy	___	___	Podiatrist	___	___

Any other medical/rehabilitative services not listed: ____

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Patient/Guardian Signature: ________________________________ *Date:* _____________