REGER PHYSICAL THERAPY

PATIENT: _____ ACCT #: _____

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 yes, please summarize:

_____

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

Have you ever had any of the following? ☐ EMG ☐ CT SCAN ☐ MYELOGRAM ☐ MRI ☐ XRAY

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

Diabetes	☐Yes	☐No
Headaches	☐Yes	☐No
Dizzy Spells	☐Yes	☐No
Fainting Spells	☐Yes	☐No
Epilepsy	☐Yes	☐No
Stroke	☐Yes	☐No
Pregnancy	☐Yes	☐No
Seizures	☐Yes	☐No
Asthma	☐Yes	☐No
Emphysema	☐Yes	☐No
Osteoporosis	☐Yes	☐No
Back Injury	☐Yes	☐No
Arthritis	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No
Fracture	☐Yes	☐No
Cancer	☐Yes	☐No
Pacemaker	☐Yes	☐No
Metal Implants	☐Yes	☐No
Respiratory Problems	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Hepatitis A, B, C	☐Yes	☐No
Heart Trouble	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Hernia	☐Yes	☐No
Kidney Problems	☐Yes	☐No
Bowel / Bladder Abnormalities	☐Yes	☐No
Liver / Gallbladder Problems	☐Yes	☐No
Smoking	☐Yes	☐No
Sexual Dysfunction	☐Yes	☐No
Skin Abnormalities	☐Yes	☐No
Nausea / Vomiting	☐Yes	☐No
Allergies	☐Yes	☐No
List:		
Other:		

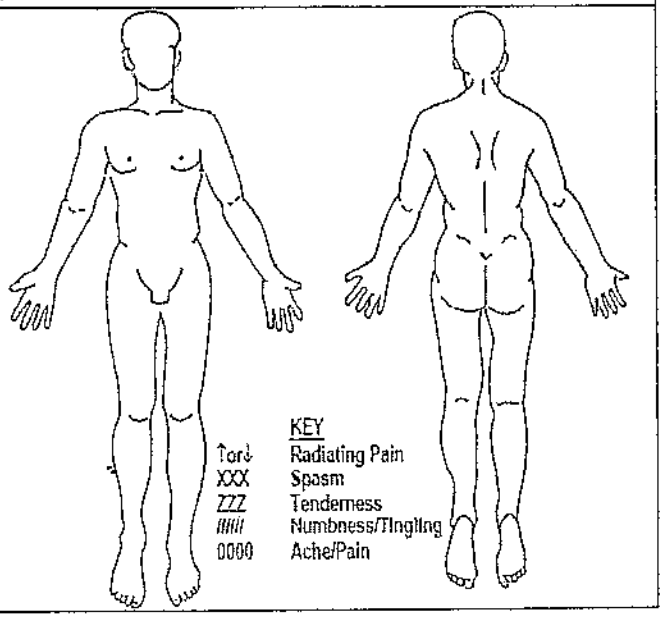
(Continue on back if needed)

Ringing in your ears	☐Yes	☐No
Rheumatoid Arthritis	☐Yes	☐No
Special Diet Guidelines	☐Yes	☐No
Hypoglycemia	☐Yes	☐No
Surgeries	☐Yes	☐No
List w/ dates:		

Please circle all that may apply. My pain is worse:
in the morning / during the day / at night / constant / with activity / during rest

On a scale of 0 to 10,
(0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain at its best _____ and at its worse _____

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



Signature of Patient or Guardian (if patient is a minor): _____ Date: _____

Relationship to patient: ☐ self ☐ guardian ☐ other: _____

Clinician's Signature: _____ Date : _____