



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

List: \_\_\_\_\_  
Other: \_\_\_\_\_

Ringling in your ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Special Diet Guidelines	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypoglycemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Surgeries	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.

**KEY**  
 ↑ or ↓ Radiating Pain  
 XXX Spasm  
 ZZZ Tenderness  
 ||||| Numbness/Tingling  
 0000 Ache/Pain

(Continue on back if needed)

Signature of Patient or Guardian (if patient is a minor): \_\_\_\_\_ Date: \_\_\_\_\_  
 Relationship to patient:  self  guardian  other: \_\_\_\_\_

Clinician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_