MEDICAL HISTORY

Patient Name: ________________________________ Date: ____/____/____

Are you presently working? ☐ Yes ☐ No Date of next physician's visit: ____/____/____

1. Have you ever had these symptoms before? ☐ Yes ☐ No

2. Check which apply to your current condition:

☐ motor vehicle accident ☐ work-related injury ☐ Recurrence of previous injury

☐ cause unknown ☐ injury related to lifting ☐ injury related to falling

☐ athletic/recreational injury ☐ other: ____

3. Have you had a related surgery? ☐ Yes ☐ No

4. If female, are you pregnant? ☐ Yes ☐ No

5. Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	**Hypoglycemia**	☐	☐
Chest pain/angina	☐	☐	**Osteoarthritis**	☐	☐
High blood pressure	☐	☐	**Osteoporosis**	☐	☐
Heart disease	☐	☐	**Hernia**	☐	☐
Heart attack	☐	☐	**Seizures**	☐	☐
Heart palpitations	☐	☐	**Metal implants**	☐	☐
Pacemaker	☐	☐	**Dizziness/fainting**	☐	☐
Headaches	☐	☐	**Fracture**	☐	☐
Kidney problems	☐	☐	**Surgeries**	☐	☐
Cancer	☐	☐	**Skin abnormalities**	☐	☐
Stroke	☐	☐	**Nausea/vomiting**	☐	☐
Bowel/bladder abnormalities	☐	☐	**Ringing in your ears**	☐	☐
Rheumatic arthritis	☐	☐			
Smoking	☐	☐	**Other:** ___________________________	☐	☐

6. Are you presently taking any medications? ☐ Yes ☐ No

If yes, please list what medications and for what condition:

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7. Do you participate in any sports, exercise programs or activities on a regular basis? ☐ Yes ☐ No