

PAST MEDICAL HISTORY

NAME: _____ D.O.B.: _____ AGE: _____
 PRIMARY PHYSICIAN: _____ REFERRING PHYSICIAN: _____
 HOBBIES: _____

STUDIES OBTAINED			
	WHEN:	WHERE:	RESULT:
X-RAY			
CT SCAN			
MRI			
BONE SCAN			
OTHER:			

PAST MEDICAL HISTORY:		
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> PERIPHERAL VASULAR DISEASE
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEART CONDITION	<input type="checkbox"/> SEIZURES
<input type="checkbox"/> BLOOD CLOTS	<input type="checkbox"/> HEPATITS	<input type="checkbox"/> STROKE
<input type="checkbox"/> CANCER	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> PACEMAKER
<input type="checkbox"/> DIABETES	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> OTHER: _____

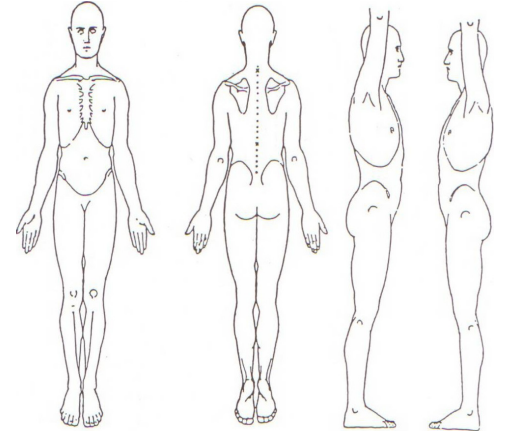
PAST SURGICAL HISTORY:	WHEN / WHERE:
<input type="checkbox"/> ORTHOPEDIC	
<input type="checkbox"/> SPINAL – UPPER	
<input type="checkbox"/> SPINAL – LOWER	
<input type="checkbox"/> HERNIA	
<input type="checkbox"/> ANGIOPLASTY	
<input type="checkbox"/> HEARTY BYPASS	
<input type="checkbox"/> BREAST	

HAVE YOU HAD RECENT SURGERY? YES NO
IF YES, WHEN/WHERE: _____
IF YES, WHAT: _____
LIVING WITH: SPOUSE FAMILY ALONE
WORKING: YES NO DISABLED RETIRED
EMPLOYER: _____
DO YOU FEEL SAFE AT HOME AND IN YOUR RELATIONSHIPS? YES NO
ARE YOU CURRENTLY PREGNANT? YES NO

CURRENT MEDICATIONS/USES:	
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

ALLERGIES TO MEDICATIONS:	
1. _____	3. _____
2. _____	4. _____

ON THE DIAGRAM BELOW, PLEASE INDICATE WHERE YOU ARE EXPERIENCING PAIN OR OTHER SYMPTOMS RIGHT NOW



ON A SCALE OF 1 – 10 WITH 10 BEING THE EXTREME WORST, WHAT IS YOUR PAIN:

Now ___/10 Best ___/10 Worst ___/10

1. How long have you had pain?
 ___ Years ___ Months ___ Weeks

2. What best describes your pain?
 ___ Sharp ___ Dull
 ___ Throbbing ___ Aches
 ___ Pins & Needles ___ Burning
 ___ Stabbing ___ Shooting
 ___ Numbness ___ Soreness
 ___ Other: _____

PATIENT SIGNATURE **DATE** **THERAPIST SIGNATURE** **DATE**

PARENT/GUARDIAN SIGNATURE **DATE**