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MEDICAL HISTORY

Name: _____ Referring Physician: _____

Are you currently taking any prescription or non-prescription medication? Yes No
 Anti-inflammatories _____ Muscle Relaxers _____ Pain Medication _____

List Medications: _____

Are you allergic to any medications? Yes No List medications: _____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

	Yes	No		Yes	No
Chiropractor	_____	_____	CT Scan	_____	_____
EMG/NCV	_____	_____	Primary Doctor	_____	_____
Massage Therapy	_____	_____	MRI	_____	_____
Myelogram	_____	_____	Neurologist	_____	_____
Occupational Therapy	_____	_____	Orthopedist	_____	_____
Physical Therapy	_____	_____	Podiatrist	_____	_____
Emergency Room	_____	_____	X-Ray	_____	_____
Other: _____					

Do you now have or have you ever had ANY of the following?

	Yes	No		Yes	No
Asthma, bronchitis, or emphysema, shortness of breath/chest pain	_____	_____	Severe or frequent headaches vision or hearing difficulties...	_____	_____
Coronary heart disease or angina.....	_____	_____	Numbness or Tingling.....	_____	_____
Do you have a pacemaker	_____	_____	Dizziness or Fainting.....	_____	_____
High blood pressure.....	_____	_____	Bowel or Bladder Problems	_____	_____
Heart Attack or Heart Surgery.....	_____	_____	Weakness.....	_____	_____
Stroke/TIA.....	_____	_____	Weight loss/energy loss.....	_____	_____
Blood Clot/Emboli.....	_____	_____	Hernia.....	_____	_____
Epilepsy/seizures.....	_____	_____	Varicose veins.....	_____	_____
Thyroid Disease or goiter.....	_____	_____	Any pins or metal implants...	_____	_____
Anemia.....	_____	_____	Joint replacement surgery...	_____	_____
Infectious Diseases.....	_____	_____	Neck injury/surgery.....	_____	_____
Diabetes.....	_____	_____	Shoulder injury/surgery.....	_____	_____
Cancer or chemotherapy/radiation.....	_____	_____	Elbow/hand injury/surgery...	_____	_____
Arthritis.....	_____	_____	Back injury/surgery.....	_____	_____
Osteoporosis.....	_____	_____	Knee injury/surgery.....	_____	_____
Gout.....	_____	_____	Leg/ankle/foot injury/surgery	_____	_____
Sleeping problems/difficulties.....	_____	_____	Are you pregnant?.....	_____	_____
Emotional/psychological problems.....	_____	_____	Do you use tobacco?.....	_____	_____

Patient/Guardian Signature: _____

Date: _____