

PATIENT NAME: _____

OCCUPATION: _____

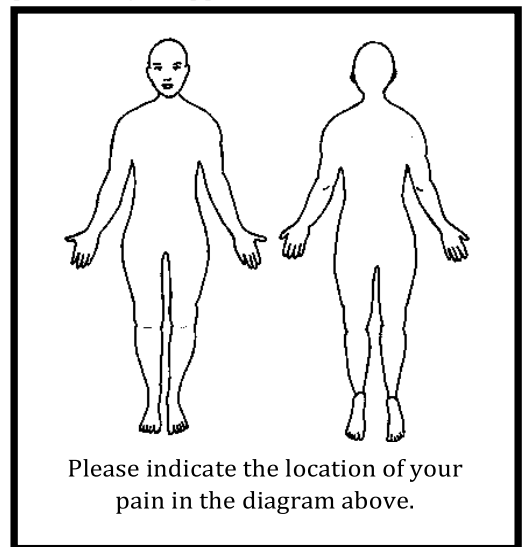
DATE OF BIRTH: ____/____/____

NEXT PHYSICIAN VISIT? _____

Medical History

Allergies	<input type="radio"/> Yes <input type="radio"/> No	Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	MRSA	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Emphysema/Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No	Muscular Disease	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Fractures	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No	Parkinsons	<input type="radio"/> Yes <input type="radio"/> No
Autoimmune Disorder	<input type="radio"/> Yes <input type="radio"/> No	Headaches	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Hearing Impairment	<input type="radio"/> Yes <input type="radio"/> No	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Conditions	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	Smoking	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Speech Problems	<input type="radio"/> Yes <input type="radio"/> No
Chemical Dependency	<input type="radio"/> Yes <input type="radio"/> No	High/Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Strokes	<input type="radio"/> Yes <input type="radio"/> No
Circulation Problems	<input type="radio"/> Yes <input type="radio"/> No	HIV/AIDS	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Currently Pregnant	<input type="radio"/> Yes <input type="radio"/> No	Incontinence	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Vision Problems	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Metal Implants	<input type="radio"/> Yes <input type="radio"/> No	Other: _____	

Describe any other conditions: If you answered, "Yes" to any of the above please explain and give approximate dates.



Average Pain Intensity:

Pain (at rest): no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Pain (at worst): no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Surgical History

Body Region: _____	Surgery Type: _____	Date of Surgery: _____
Body Region: _____	Surgery Type: _____	Date of Surgery: _____
Body Region: _____	Surgery Type: _____	Date of Surgery: _____
Body Region: _____	Surgery Type: _____	Date of Surgery: _____

Current Medications and/or Supplements: Please provide a copy of your medication list if additional space is needed.

Drug: _____	Dosage: _____	Frequency: _____	Route: _____	Reason for Taking: _____
Drug: _____	Dosage: _____	Frequency: _____	Route: _____	Reason for Taking: _____
Drug: _____	Dosage: _____	Frequency: _____	Route: _____	Reason for Taking: _____
Drug: _____	Dosage: _____	Frequency: _____	Route: _____	Reason for Taking: _____
Drug: _____	Dosage: _____	Frequency: _____	Route: _____	Reason for Taking: _____
Drug: _____	Dosage: _____	Frequency: _____	Route: _____	Reason for Taking: _____