



MEDICAL HISTORY AND PREVIOUS TREATMENT FORM

PATIENT NAME: _____ DATE: _____

Please check if you have been diagnosed with any of the following conditions:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Diabetes(I/II) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke (TIA or CVA) | <input type="checkbox"/> Seizures | <input type="checkbox"/> Metal Implants |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> Infectious Diseases (HIV, Hepatitis B, Hepatitis C, TB, etc.) _____ | | | |
| <input type="checkbox"/> Other: _____ | | | |

Surgical History: _____

During the past month have you been feeling down, depressed, or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Please list all medications you are currently taking (prescribed and over the counter): _____

Have you recently noted?

- | | | | | | |
|-----|----|---------------------------|-----|----|---|
| YES | NO | Weight loss/gain | YES | NO | Nausea/Vomiting |
| YES | NO | Dizziness/Lightheadedness | YES | NO | Unusual weakness |
| YES | NO | Fever/chills/sweats | YES | NO | Visual problems |
| YES | NO | Incontinence | YES | NO | Hearing problems |
| YES | NO | Bleeding | YES | NO | Pregnant or think you might be pregnant |

Date of onset of current symptoms/injury: _____

Have you had the same or a similar problem in the past? YES NO

If yes, please explain: _____

Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications etc. _____

Have you received X-rays, MRI, CT scan, Bone Scan, etc for this problem? _____

Has your doctor discussed your medical findings or given you a diagnosis? YES NO

If yes, what were the findings? _____

Do you require this therapy to return to prior level of function? YES NO

What are your goals for recovery? _____

Are you aware of any physical reason why you should not receive treatment? YES NO

If yes, please tell us what it is: _____

Do you have any allergies? YES NO. If yes, please list: _____

To the best of my knowledge the above information is accurate and complete

Signature: _____ Date: _____

Thank you for completing this questionnaire. It will allow us to better serve your needs.

Therapist signature: _____ Date: _____