

Medical History Form

Name _____

Have you ever been diagnosed with any of the following?

Date of Birth _____

Tuberculosis <input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis <input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes	Cardiovascular Problems <input type="checkbox"/> No <input type="checkbox"/> Yes	Respiratory Problems <input type="checkbox"/> No <input type="checkbox"/> Yes
Other <input type="checkbox"/> No <input type="checkbox"/> Yes explain: _____		



Tell Us About Your Condition

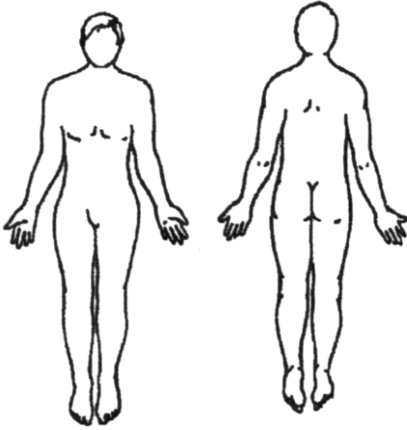
When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates)

First Episode: _____ Most Recent Episode: _____

What is your main problem related to this condition? _____

How did your injury/symptoms occur? _____

Indicate on body diagrams **where** your symptoms are located  Pain  Numbness



Are your symptoms: Constant Intermittent

Are your symptoms: Getting Better Getting worse Staying the same

What makes your symptoms better? _____

For this injury, has your medical care included:(check those that apply)

Surgery: When? _____ What kind? _____

Injection: When? _____ Did it help? Yes No

Other treatment: Physical therapy If yes, when? _____ to _____
What was done? _____

Chiropractor If yes, when? _____ to _____
What was done? _____

Exercises: What kind? _____
Problems? No Yes _____

Choose the appropriate column and indicate, Yes or No, as to whether each of the following activities are *difficult* pertaining to your injury or complaint.

UPPER BODY AND NECK		LOWER BODY AND LOW BACK	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Drinking or eating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Getting in and out of <input type="checkbox"/> chairs <input type="checkbox"/> bed <input type="checkbox"/> car <input type="checkbox"/> bath/shower
<input type="checkbox"/> Yes <input type="checkbox"/> No	Getting in and out of <input type="checkbox"/> chairs <input type="checkbox"/> bed <input type="checkbox"/> car	<input type="checkbox"/> Yes <input type="checkbox"/> No	Balancing on one or both feet
<input type="checkbox"/> Yes <input type="checkbox"/> No	Putting on/taking off shoes, shirts, jackets	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sitting
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep through the night	<input type="checkbox"/> Yes <input type="checkbox"/> No	Driving a vehicle
<input type="checkbox"/> Yes <input type="checkbox"/> No	Reaching: <input type="checkbox"/> overhead <input type="checkbox"/> behind back <input type="checkbox"/> down <input type="checkbox"/> forward	<input type="checkbox"/> Yes <input type="checkbox"/> No	Standing
<input type="checkbox"/> Yes <input type="checkbox"/> No	Ability to sit	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ability to use foot controls in vehicle
<input type="checkbox"/> Yes <input type="checkbox"/> No	Maintaining position of <input type="checkbox"/> head forward bent, <input type="checkbox"/> arms overhead, <input type="checkbox"/> arms forward, <input type="checkbox"/> turning head	<input type="checkbox"/> Yes <input type="checkbox"/> No	Walking on: <input type="checkbox"/> flat surfaces, <input type="checkbox"/> inclines or uneven surfaces, <input type="checkbox"/> stairs or ladders
<input type="checkbox"/> Yes <input type="checkbox"/> No	Picking up small objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep through the night
<input type="checkbox"/> Yes <input type="checkbox"/> No	Gripping, holding tools, opening jars	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dressing: putting on/taking off shoes, shirts, pants, jacket
<input type="checkbox"/> Yes <input type="checkbox"/> No	Lifting or carrying	<input type="checkbox"/> Yes <input type="checkbox"/> No	Running/recreation
<input type="checkbox"/> Yes <input type="checkbox"/> No	Housework/yardwork(i.e., vacuum, dust, sweep, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bending
<input type="checkbox"/> Yes <input type="checkbox"/> No	Ability to care for children or dependent adult	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kneeling
<input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational activities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Squatting
<input type="checkbox"/> Yes <input type="checkbox"/> No	Job activities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lifting or carrying
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Housework/yardwork (i.e., vacuum, dust, sweep, etc.)
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Ability to care for children or dependent adult
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Perform overhead activities
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Job activities: _____
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____

Rate your pain, circle appropriate number

10=unbearable 0=pain free

At it's worst: 0-1-2-3-4-5-6-7-8-9-10

At it's best: 0-1-2-3-4-5-6-7-8-9-10

Currently: 0-1-2-3-4-5-6-7-8-9-10