



Patient History

Name: _____ Sex: M F Age: ____ Date of Birth: _____

Please complete all requested information.

1. Have you ever had: (If Yes, please explain)

High Blood Pressure	no	yes	_____
Heart or circulation Disorders	no	yes	_____
Seizures	no	yes	_____
Dizzy Spells	no	yes	_____
Cancer	no	yes	_____
Arthritis/Osteoarthritis	no	yes	_____
Osteoporosis	no	yes	_____
Immune Deficiency Disease	no	yes	_____
Other	no	yes	_____

2. Please list surgeries you have had and dates, if possible:

3. Please list recent diagnostics studies (X-rays, MRI, CT Scan):

4. Do you have any metal anywhere in your body, pins/plates post fracture, or pacemaker? No/Yes

5. (For women only) Are you now pregnant? No/Yes

6. Do you have any abnormal trouble with vision? No/Yes Hearing? No/Yes

7. List any Allergies you have:

8. Have you ever taken steroids or anti-coagulants for an extended period of time? No/Yes

9. Have you had an unusual weight gain or loss lately? No/Yes

10. List any medications you are now taking: _____

11. Have you ever had physical therapy treatments before? No/Yes

If yes, please indicate when and for what problem: _____

12. Describe briefly the history of your present Accident, Injury, or Illness

Onset Date: _____

Description: _____

13. Date of next Doctor appointment: _____