Medical History

Today's Date Patient Name:

General Information

1. Is this injury related to? ☐Work ☐ Car Accident☐ Other Liability/Potential Lawsuit ☐Not Applicable
2. Do you have a Primary Care Physician / Family Doctor? ☐No ☐Yes
   If yes, have you had an appointment with him / her in the last 12 months? ☐No ☐Yes
3. Race/Ethnicity (Please select one):
   ☐Hispanic or Latino Origin (includes Mexican, Cuban, Puerto Rican, and other Latin American and Spanish) ☐Not Hispanic ☐African American ☐Caucasian (White) ☐Asian or Pacific Islander ☐Native American, Eskimo, or Aleutian ☐Other ☐Declined

If you are a Medicare beneficiary, you are required by Medicare to answer the following question:

4. Do you consume more than 7 alcoholic drinks in a week? ☐ Yes ☐ No

Please Mark One Box For Each Item	No	Yes Under a year	Yes Over a year	No Answer /Invalid	**Please Mark One Box For Each Item**	No	Yes Under a year	Yes Over a year	No Answer /Invalid
Smoking	☐	☐	☐	☐	Sexual dysfunction	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Bladder / bowel problems	☐	☐	☐	☐
Heart condition	☐	☐	☐	☐	Groin numbness	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	Arthritis	☐	☐	☐	☐
Chest pain	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	Psychological condition	☐	☐	☐	☐
Kidney condition	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
Blood clot / DVT	☐	☐	☐	☐	Dizziness / faintness	☐	☐	☐	☐
Metal implants / pacemaker	☐	☐	☐	☐	Ringing in ears	☐	☐	☐	☐
Breathing difficulties / asthma	☐	☐	☐	☐	Allergy to latex (gloves)	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Other allergy	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	Head Injury	☐	☐	☐	☐
Circulation/vascular problems	☐	☐	☐	☐	Obesity	☐	☐	☐	☐
Peripheral neuropathy	☐	☐	☐	☐	Chronic pain/fibro/headaches	☐	☐	☐	☐
Unexplained weight loss	☐	☐	☐	☐	Fractures	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	Infection	☐	☐	☐	☐
Night sweats / night pain	☐	☐	☐	☐	Fever / nausea	☐	☐	☐	☐
					Are you pregnant?	☐	☐	☐	☐

	No	Yes	If yes, please specify the condition
Infection Disease	☐	☐	
Neurologic Condition (MS/Parkinson's)	☐	☐	
Pediatric Developmental Condition	☐	☐	
Skin Disease	☐	☐	
Spinal Cord Injury	☐	☐	
Degenerative Joint Disease	☐	☐	☐Spine☐ Upper Extremity ☐Lower Extremity

Medical History

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Patient Medication List

Please list ALL medications (including prescription, over –the-counter, vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

Medication	Dosage	Frequency	Route of Administration