Medical History Form

Name:______________________________________Occupation:__________________________Age:____

Chief Compliant: ____

Date of Onset: (injury/problem/surgery)____

Briefly state any previous treatment, if any: ____

____

Do you currently have, or have any history of the following conditions?

Condition	YES	NO
Diabetes		
High Blood Pressure		
Pacemaker		
Chronic headaches		
Kidney problems		
Nervous system disorders		
Hernia		
Sensitivity to heat		
Sensitivity to cold		
Bone disease		
Fractures		

Condition	YES	NO
Bladder Problems		
Pins and needles		
Seizures		
Metal implants		
Dizziness		
Cancer		
Pregnancy		
Osteoporosis		
Bowel problems		
Recent weight loss or gain		
Circulatory disease		

Please provide your estimated height and weight:____

If Yes to any of the above, please explain:____

____

____

Have you ever had surgery? Please provide surgery and date, if possible: ___________________________

____

Please list any medications you are currently taking: ____

____

Have you had any X-rays, CAT Scans, MRIs, or other diagnostic testing for this recent disorder?
YES___NO___ If yes, please explain the results as you understand them:

____

____

Is there any other information that you think is important for us to know about your general health, current condition, or past medical history? ____

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