MEDICAL HISTORY

Your medical history is an important part of your treatment. Please complete this form.

Date: _____ Part of body to be treated: _____

Patient's name: _____ Sex: M F

Age: _____ Height: _____ Weight: _____ Are you: right handed left handed both

Do you smoke? _____ Do you drink alcohol? _____ Amount: _____

Food or drug allergies: _____

Past medical history: _____

Illnesses: _____

_____

Surgeries: _____

_____

Medications/herbs: _____

_____

Family History: High blood pressure Diabetes Cancer Stroke Heart attack

Rheumatoid arthritis Club foot Dislocated hips Tuberculosis

Bleeding tendency Gout Other: _____

Present medical history: _____

_____

Present medications/herbs: _____

_____

Activities/hobbies: _____

Chief complaint: _____

Was this an injury? Yes / No Date of injury?: _____

History of injury: (How it occurred) _____

Redness? Yes / No Swelling? Yes / No Accompanied by fever? Yes / No

Does problem area: *Click*? Yes / No *Snap*? Yes / No *Catch*? Yes / No *Pull*? Yes / No

Location of pain: _____

Does it seem to be getting better or worse? _____

What aggravates the problem? _____

Previously treated for this problem? Yes / No

If so, by whom? _____ Orthopedist? Yes / No

Was physical therapy prescribed? Yes / No Did it help your symptoms? Yes / No

Did you have x-rays taken? Yes / No Where were x-rays taken? _____

How old are the x-rays? _____

Comments: _____

_____

Are you currently working? Yes / No What is your occupation? _____

If industrial injury, are you working for the same employer? Yes / No

What is your job description? _____