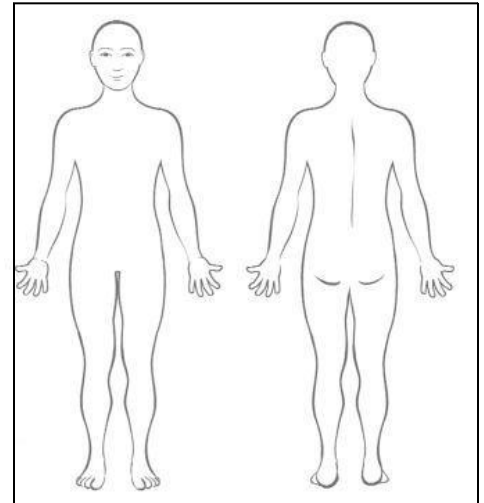

Name: _________________________________ Date: _____________
What is your primary problem? ___________________________________
Secondary problem? ____
How did your problems begin? ___________________________________
_______________________________ When? __________________________
What is your Occupation? _______________________________________
Are your problems work related? ______ Yes ______ No
What makes your pain worse? ____________________________________
What eases your pain? ____
Can you get comfortable at night? YES / NO
How do you feel upon rising in the morning? Stiff ____ Sore ____ Fine ____
What is it like at the end of the day? Worse ____ Easier ____
Please describe your problems using the diagram to the right=>

Patient Medical History

Do you now have or have you ever had ANY of the following?

	Yes	No		Yes	No		Yes	No
Allergies	___	___	Depression	___	___	Multiple Sclerosis	___	___
Anemia	___	___	Diabetes	___	___	Osteoporosis	___	___
Anxiety	___	___	Dizzy Spells	___	___	Parkinson’s	___	___
Arthritis	___	___	Emphysema/Bronchitis	___	___	Rheumatoid Arthritis	___	___
Asthma	___	___	Fracture	___	___	Seizures	___	___
Cancer	___	___	Gallbladder Problems	___	___	Speech Problems	___	___
Cardiac Conditions	___	___	Hepatitis	___	___	Strokes	___	___
Cardiac Pacemaker	___	___	High Blood Pressure	___	___	Thyroid Disease	___	___
Chemical Dependency	___	___	Incontinence	___	___	Tuberculosis	___	___
Circulation Problems	___	___	Kidney Problems	___	___	Vision Problems	___	___
Currently Pregnant	___	___	Metal Implants	___	___			

Describe any other conditions or precautions:

Fall History:	Yes	No
Injury as a result of a fall in the past year?	___	___
Two or more falls in the last year?	___	___

Surgical History:
Body Region: ___________________________ Surgery Type: ____________________________ When: ____ / ____ / ____

Current Medications: Please list all **prescription medications** and **over-the-counter** (herbal supplements, low dose aspirin, vitamins, etc…) you are currently taking. If you have a printed list available, we can also copy it for you.

Name:________________________________ Dosage: __________ Frequency: ____________________ Route: _________
Name:________________________________ Dosage: __________ Frequency: ____________________ Route: _________
Name:________________________________ Dosage: __________ Frequency: ____________________ Route: _________
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