MEDICAL HISTORY INFORMATION:

To ensure that you receive a complete and thorough evaluation, please provide us with this important background information regarding your medical history. If you do not understand a question your therapist will help you. Thank you!

Date: ___________________

Name: _________________________________ Age:_____________

Have you ever been diagnosed with any of the following conditions?

YES NO Cancer. If yes, please describe: _________
YES NO Rheumatoid arthritis
YES NO High blood pressure
YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke
YES NO Kidney disease
YES NO Thyroid problems
YES NO Epilepsy
YES NO Heart Problems. If yes, please describe:_________
YES NO Pacemaker
YES NO Depression
YES NO Other arthritis conditions
YES NO Chemical dependency
YES NO Circulation problems
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Anemia
YES NO Diabetes
YES NO Multiple sclerosis
YES NO Osteoporosis
OTHER ___________________________

For women: Are you pregnant or think you might be? YES NO

Please describe any surgeries or other significant injuries for which you have been treated or hospitalized.

DATE	**INJURY/SURGERY**	**DATE**	**INJURY/SURGERY**

Please list any prescription medication you are currently taking.

1. ____________________________ 2. ________________________ 3. ________________
4. ____________________________ 5. ________________________ 6. ________________

Have you recently noted any of the following:_

YES NO Weight loss/gain. If yes, how much?____________
YES NO Nausea/vomiting
YES NO Fatigue
YES NO Weakness
YES NO Fever/chill/sweats
YES NO Numbness/tingling

Briefly describe location of pain ____

Please list any allergies we should know about. ________________________________

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