

MEDICAL HISTORY FORM

Name _____ SS# _____/_____/_____

Address _____

Telephone (_____) _____ Age _____ DOB _____/_____/_____

Do you smoke? YES NO Pack per day? _____ How many years? _____

Please circle YES or NO to indicate if you have ever experienced the following:

Neck Pain	YES / NO	Immune Deficiencies	YES / NO
Mid Back Pain	YES / NO	Venereal Disease	YES / NO
Low Back Pain	YES / NO	Cancer	YES / NO
Radiating Pain in the Arms or Legs	YES / NO	High Blood Pressure	YES / NO
Numbness or tingling in any part of the body	YES / NO	Stomach Problems	YES / NO
Bowel/Bladder Control Problems	YES / NO	Intestinal Disorders	YES / NO
Muscle Tightness or Spasm	YES / NO	Hepatitis/Liver Disease	YES / NO
Joint Pain or Stiffness	YES / NO	Blood Disorder	YES / NO
Pulled/Strained Muscle	YES / NO	Heart Problem	YES / NO
Torn Ligament	YES / NO	Vascular Disease	YES / NO
Any Fracture or Broken Bones	YES / NO	Stroke	YES / NO
Pain in the Back or Neck during sneezing, coughing or bowel movements	YES / NO	Muscle Paralysis	YES / NO
Blood in the urine or stool	YES / NO	Polio	YES / NO
Unusual weakness in the arms, hands or legs	YES / NO	Hernias	YES / NO
Unexplained weight loss or gain	YES / NO	Kidney Problems (stones, infections, etc.)	YES / NO
Pain in the legs while walking	YES / NO	Scoliosis (curvature of spine)	YES / NO
Chest Pains	YES / NO	Hip, Knee or Ankle/Foot Disorder	YES / NO
Frequent or Severe Headaches	YES / NO	Pelvic or Sacral Problems	YES / NO
Dizziness or Blurred Vision	YES / NO	Uterine Problems (e.g. Endometriosis)	YES / NO
Diabetes	YES / NO	Ovarian Problems (e.g. Cyst)	YES / NO
Arthritis (Rheumatoid/Degenerative)	YES / NO	Menstrual Pain	YES / NO
Gout	YES / NO	Urinary Tract Infection	YES / NO
Neurological Disease	YES / NO	Hormonal Problems	YES / NO
Muscle Disease	YES / NO	Pregnancy	YES / NO

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Have you ever had or now have health problems not indicated in the previous questions?

List any medications that you are taking at present or have recently taken:

Indicate all surgeries that you have had or expect to have:

Have you ever had an x-ray, MRI, CT Scan, EMG, or other special test?

If you have any concerns or additional comments, please list them now:

Some illness and conditions are genetically transferred or may be occupationally related. It is useful for us to know what conditions you or your family members have or have had in the past. Please tell us if you or a family member have or have had:

CONDITION	YOU	WHEN?	FAMILY MEMBER	WHEN?
Arthritis				
Rheumatism				
Back Pain				
Neck Pain				
Sprain/Strain				
Headaches				
Hand Problems				
Shoulder Problems				
Knee Pain				
Hip Pain				
Foot/Ankle Pain				
Other				

Signature _____

Printed Name _____

Date ____/____/____