

# Medical History

Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_

## Existing or Relevant Previous Conditions

Allergies	<input type="radio"/> Yes <input type="radio"/> No	Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	MRSA	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Emphysema/Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No	Muscular Disease	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Fractures	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No	Parkinson's	<input type="radio"/> Yes <input type="radio"/> No
Autoimmune Disorder	<input type="radio"/> Yes <input type="radio"/> No	Headaches	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Hearing Impairment	<input type="radio"/> Yes <input type="radio"/> No	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Conditions	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	Smoking	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Speech Problems	<input type="radio"/> Yes <input type="radio"/> No
Chemical Dependency	<input type="radio"/> Yes <input type="radio"/> No	High/Low blood pressure	<input type="radio"/> Yes <input type="radio"/> No	Strokes	<input type="radio"/> Yes <input type="radio"/> No
Circulation Problems	<input type="radio"/> Yes <input type="radio"/> No	HIV/AIDS	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Currently Pregnant	<input type="radio"/> Yes <input type="radio"/> No	Incontinence	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Vision Problems	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Metal Implants	<input type="radio"/> Yes <input type="radio"/> No		

## Describe any other conditions / medical precautions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Briefly describe your symptoms: \_\_\_\_\_

How did your symptoms start: \_\_\_\_\_

Average pain intensity? No Pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Worst Pain

How often do you experience your symptoms?

Constantly (76-100% of time)    Frequently (51-75% of time)    Occasionally (26-50% of time)    Intermittently (0-25% of time)

How much have your symptoms interfered with your usual daily activities? (including both work and home)

Not at all    A little bit    Moderately    Quite a bit    Extremely

In general, would you say your overall health right now is...

Excellent    Very good    Good    Fair    Poor

## Fall History

Injury as a result of a fall in the past year?  Yes  No

Two or more falls in the last year?  Yes  No

## Surgical History

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

## Current Medications

Currently not taking any medications

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Additional information here:

---

---

---

---

---

---

---

---

---

---