

INTERNET FORM



Medical History Form

Patient Name: _____ Account Number: _____

Height: _____ ft _____ in Weight: _____ (pounds) Date of injury: _____

Diagnosis as stated to you by your physician: _____

How did this injury/ exacerbation occur? _____

Have you been hospitalized for the present condition? Yes No If Yes, date: _____

Have you had surgery for the present condition? Yes No If Yes, date: _____

If yes, surgery type: _____

Have you had any falls this past year? Yes No If Yes, how many? _____

Have you received previous treatment for this condition? Yes No If Yes, date: _____

If yes, please summarize: _____

Have you ever had any of the following? EMG CT SCAN MYELOGRAM MRI XRAY

Have you ever, or are you presently being treated for any of the following conditions?

| | | |
|---|------------------------------|-----------------------------|
| Acquired Respiratory Distress Syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anxiety or Panic Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis (RA, OA) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congestive Heart Failure (CHF) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hearing Impairment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Attack | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Multiple Sclerosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Osteoporosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Parkinson's Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Peripheral Vascular disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke or TIA | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Upper Gastrointestinal Disease (ulcer, hernia, reflux) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Visual Impairment (cataracts, glaucoma, macular degeneration) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| | | |
|---|------------------------------|-----------------------------|
| Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back Injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bowel / Bladder Abnormalities | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dizzy or Fainting Spells | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy or Seizure Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fracture | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis A, B, C | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV/AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypoglycemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Immunosuppressant Condition or Medication | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Liver / Gallbladder Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Metal Implants | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nausea / Vomiting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Defibrillator | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pregnancy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ring in Your Ears | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sexual Dysfunction | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skin Abnormalities | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Smoking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Special Diet Guidelines | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Patient Name: _____ Account Number: _____

Are you on any medications? Click here if attached: Attached Please list (you may use reverse side):

To help us understand your symptoms, please circle all that apply.

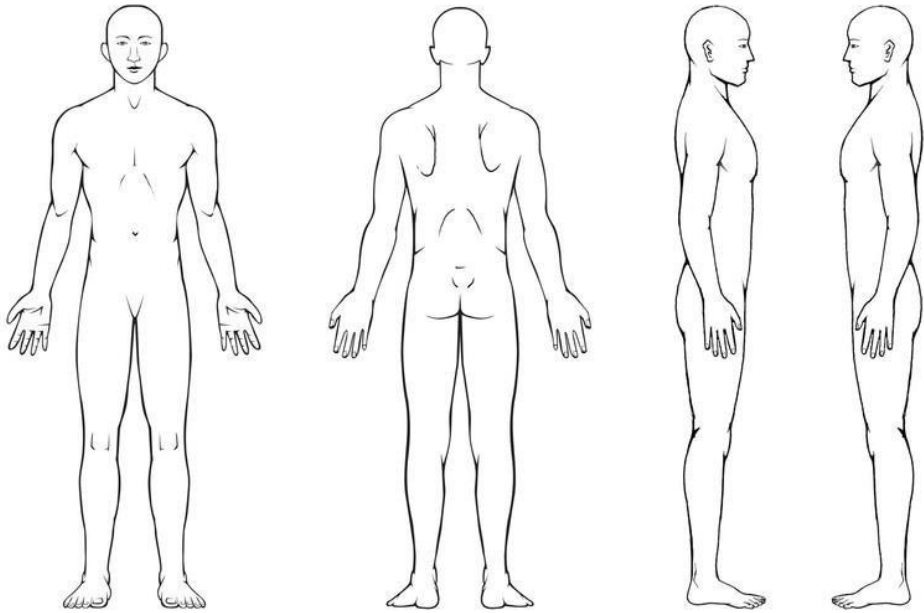
My pain is worse: in the morning/ during the day/ at night/ constant/ with activity/ during rest

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best _____ and at its worst _____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



Key

| | |
|-----------------------|------------------------|
| ↑ or ↓ Radiating Pain | //// Numbness/Tingling |
| XXX Spasm | 000 Ache/Pain |
| ZZZ Tenderness | |

Is there any other information regarding your medical history that we should know about? _____

What is your goal for therapy at this time? _____

Signature of Patient or Guardian (if patient is a minor): _____ Date: _____