MEDICAL HISTORY AND PHYSICAL CONDITION

NAME: _____ DATE: _____

Chief Complaint: _____ Date of Injury / Onset: _____

1. Do you now have or have you in the past, had any of the following conditions:

Allergies	yes☐ no☐	Hernia	yes☐ no☐
Balance Problems	yes☐ no☐	High Blood Pressure	yes☐ no☐
Cancer	yes☐ no☐	HIV / AIDS	yes☐ no☐
Circulatory Problems	yes☐ no☐	Kidney Problems	yes☐ no☐
Diabetes	yes☐ no☐	Nervous Disorder	yes☐ no☐
Dizzy Spells	yes☐ no☐	Numbness / Tingling	yes☐ no☐
Headaches	yes☐ no☐	Pregnancy	yes☐ no☐
Hearing/Vision Problems	yes☐ no☐	Respiratory Problems	yes☐ no☐
Heart Attack	yes☐ no☐	Seizures	yes☐ no☐
Heart Disease	yes☐ no☐	Sensitivity to heat/cold	yes☐ no☐

If yes to any of the above, please explain and give approximate dates of occurrences:

_____

_____

2. Have you had treatment for this / these problems before? Yes ☐ No ☐

   If yes, where and when were you treated? _____

3. Have you had surgery related to this / these problems? Yes ☐ No ☐

   If yes, what type of surgery did you have and when was the surgery? _____

4. Do you currently have any metal implants? Yes ☐ No ☐

5. Do you currently have a pacemaker? Yes ☐ No ☐

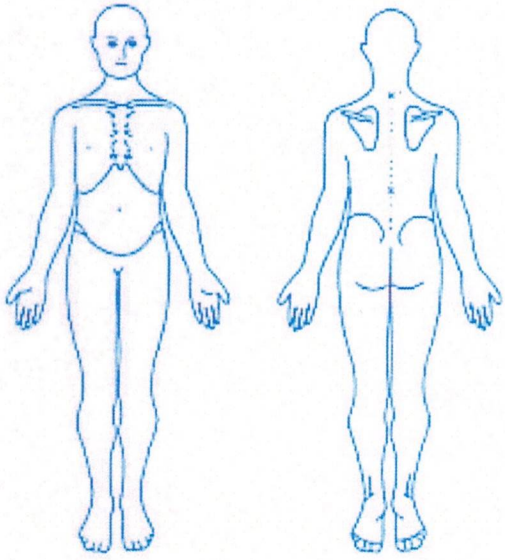
6. Do you have any communicable diseases? Yes ☐ No ☐

7. List all medications you are currently taking, including vitamins/supplements:

_____ _____ _____ _____

_____ _____ _____ _____

Please indicate on the body chart below, the location of your injury or condition. Also indicate the quality of your injury, condition, or pain (i.e., ache, sharp, dull, weakness, shooting, etc.)



On a scale from 0 to 10, please indicate the range of your discomfort/pain (best to worst):

0 1 2 3 4 5 6 7 8 9 10

NO PAIN UNBEARABLE

Symptoms are aggravated by: _____

Symptoms are eased by: _____

Symptoms are better in the: am_____ pm_____

Please check those activities that you are unable to perform since your injury / surgery and would like to resume.

Walking	[ ]
Running	[ ]
Going up/down stairs	[ ]
Bending	[ ]
Lifting	[ ]
Sitting	[ ]
Standing	[ ]
Throwing	[ ]
Reaching overhead	[ ]

Activities of Daily Living:

Dressing	[ ]
Grooming	[ ]
Eating	[ ]
Cleaning	[ ]
Driving	[ ]

Other: _____ Sports Activities: _____

_____ _____

Patient Name Date