MEDICAL HISTORY FORM

Last Name: ____________________________ **First Name**: ____________________ **D.O.B**: _____________________

Primary concern for today's appointment: ____

PRESENT INVOLVMENT IN ANY OTHER HEALTH CARE:

☐ Chiropractic ☐ Physiotherapy ☐ Massage ☐ Osteopathy ☐ Other:______________________

SOFT TISSUE AND JOINT (Problem areas)

☐ Shoulder ☐ Hip ☐ Muscle weakness/soreness

☐ Arm/Elbow ☐ Leg/Knee ☐ Spine___________

☐ Hand/Wrist ☐ Ankle/Feet ☐ Neck ☐Other: ___________

LIFESTYLE

☐ Exercise ☐ Cigarettes

☐ Alcohol (# of drinks per month:___)

☐ Coffee/Tea ☐ Drug use ☐ Other:_________

HEALTH HISTORY – Please indicate all that you currently have or have had in the past:

General

☐ Loss of consciousness
☐ Blackouts
☐ Fainting
☐ Dizziness
☐ Numbness/pain/tingling
☐ Bruising
☐ Headaches/Migraines
☐ Shortness of Breath
☐ Loss of sleep
☐ Loss of weight
☐ Depression and/or anxiety
☐ Fatigue
☐ Joint Instability
☐ Hearing/Vision Loss
☐ Loss of Sensation
☐ Autoimmune disorder

Cardiovascular

☐ High blood pressure
☐ Low blood pressure
☐ Heart Attack/Stroke
☐ Rapid heartbeat
☐ Pace Maker
☐ Chest Pain
☐ Heart murmur
☐ Buerger's Disease
☐ Anaphylactic Shock
☐ Poor circulation
☐ Aneurysms
☐ Hemophilia
☐ Varicose/Spider Veins
☐ Thrombosis
☐ Chest pains
☐ Phlebitis

Muscles & Joints

☐ Fibromyalgia/Polymylgia
☐ Ankylosing Spondylitis
☐ Scoliosis
☐ Arthritis
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Reiter's Syndrome
☐ Swollen joints

Skin

☐ Hives/Boils
☐ Skin Irritation/ itching
☐ Eczema/psoriasis
☐ Bruise easily
☐ Infectious skin condition
☐Scleroderma

Other Conditions

☐ Epilepsy
☐ Anemia
☐ History of cancer
☐ Lupus
☐ Hepatitis
☐ Hernia
☐ Diabetes Type 1 ☐ 2☐
☐ Parkinson's
☐ Gout
☐ HIV/Aids
☐ Multiple Sclerosis
☐ Flaccid Paralysis
☐ History of seizures
☐Osteoporosis
☐Thyroid problems
☐Ulcers

Respiratory

☐ Asthma ☐ Chronic Cough ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Sleep

☐ Bronchitis ☐ Emphysema ☐ Immunological disease ☐ Breathing difficulty ☐ Tuberculosis ☐ Cystic Fibrosis

Other

☐ Pins/Plates/Wires (please specify location:_________) ☐ Allergies (please specify______) ☐ Undiagnosed Lump

☐ Pelvic Inflammatory Disease ☐ Cosmetic Implants ☐ Currently pregnant (Due date:_______) ☐ Endometriosis

☐ Chronic Kidney Disease ☐ Difficulty swallowing ☐ Neuritis (swollen nerve)

☐ Other genetic disorder (please specify:_______________) ☐ Bladder dysfunction ☐ Bowel dysfunction

Other (please specify): ____

Current Medication(s) (dosages and reason): ____

PAST SURGERIES OR INJURIES:	DATE	TREATMENT RECEIVED
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

All information is confidential and will not be released without your written consent.

I certify that the information in this form is true and accurately reflects my past and present health status:

_________________________________ _________________________________ ___________________

Patient/Guardian (Please Print Name) Signature Date