ADVANCED KINETICS

# MEDICAL HISTORY QUESTIONNAIRE

| | | | |
|---|---|---|---|
| **Name** *(Last, First, M.I.):* | ☐ M ☐ F | **DOB:** | |
| **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | | | |
| **Previous or referring doctor:** | | **PRIMARY DIAGNOSIS** | |

## PERSONAL HEALTH HISTORY

| | | |
|---|---|---|
| **INJURY:**<br>☐ Work related<br>☐ Motor Vehicle Accident<br>☐ Previous injury/exacerbation<br>☐ Athletic related<br>☐ Post Surgical (DATE: )<br>☐ Other | **DATE OF INJURY?** | **Do you currently exercise?** |
| | **Have you been treated for this condition previously:** ☐ Yes ☐ No<br>If yes please explain | **Are you allergic to Latex** ☐ Yes ☐ No<br>**Are you currently working:** ☐ Yes ☐ No<br>**What is your occupation?**<br>**Hours per week?**<br>**Last day of work?**<br>**Estimated return to work** |

**List any medical problems that other doctors have diagnosed**

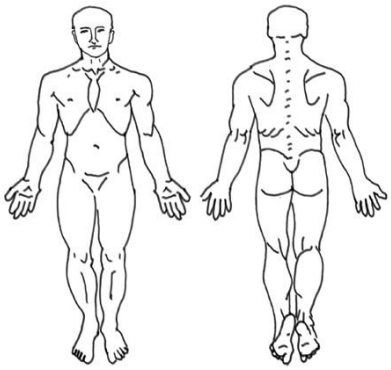
Current List of medications:

| **PAST SURGICAL HISTORY** | | **Have you had any recent Diagnosistic tests?** | |
|---|---|---|---|
| Year | Reason | X- Rays | |
| | | MRI | |
| | | CT Scan | |
| | | Other | |

**PAIN SCALE: PLEASE RATE YOUR PAIN**

| | |
|---|---|
| **CURRENTLY** | ☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9 ☐10 |
| **AT WORST** | ☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9 ☐10 |
| **AT BEST** | ☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9 ☐10 |
| | |
| **Do you have frequent falls?** | ☐ Yes ☐ No How Often? |
| **Could you be pregnant?** | ☐ Yes ☐ No |
| **Do you have a bleeding disorder?** | ☐ Yes ☐ No |

X-burning
O-tingling
N-numbness
**-throbbing
++-stiffness
//-aching



## MEDICAL HISTORY

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | Heart attack or heart disease? | ☐ yes ☐ no | ☐ | Allergies? | ☐ yes ☐ no | ☐ | Are you taking blood thinners | ☐ yes ☐ no |
| ☐ | High blood pressure? | ☐ yes ☐ no | ☐ | Changes in Bladder? | ☐ yes ☐ no | ☐ | Asthma? | ☐ yes ☐ no |
| ☐ | Pacemaker? | ☐ yes ☐ no | ☐ | Changes in Bowel? | ☐ yes ☐ no | ☐ | Metal Implants? | ☐ yes ☐ no |
| ☐ | Cancer? | ☐ yes ☐ no | ☐ | Recent changes in weight loss or gain? | ☐ yes ☐ no | ☐ | Recent Fractures? | ☐ yes ☐ no |
| ☐ | Parkinson's? | ☐ yes ☐ no | ☐ | Dizziness/fainting? | ☐ yes ☐ no | ☐ | Ehlers Danlos? | ☐ yes ☐ no |
| ☐ | Diabetes? | ☐ yes ☐ no | ☐ | Nausea/Vomiting? | ☐ yes ☐ no | ☐ | Sensitivity to heat or cold? | ☐ yes ☐ no |
| ☐ | Arthritis? | ☐ yes ☐ no | ☐ | Depression/Anxiety? | ☐ yes ☐ no | ☐ | Vision or hearing difficulty? | ☐ yes ☐ no |
| ☐ | Osteoporosis? | ☐ yes ☐ no | ☐ | Headaches? | ☐ yes ☐ no | ☐ | Have you smoked? | ☐ yes ☐ no |
| ☐ | Anemia? | ☐ yes ☐ no | ☐ | Unusual Fatigue? | ☐ yes ☐ no | ☐ | Are you pregnant? | ☐ yes ☐ no |