ADVANCED KINETICS

MEDICAL HISTORY QUESTIONNAIRE

Name (Last, First, M.I.):	**Chosen Name/Nickname:**
Pronouns: ☐ **She/Her** ☐ **He/Him** ☐ **They/Them** ☐ **Other**	**DOB:**
Doctor:	**Reason For Visit**

PERSONAL HEALTH HISTORY

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

List any medical problems that other doctors have diagnosed

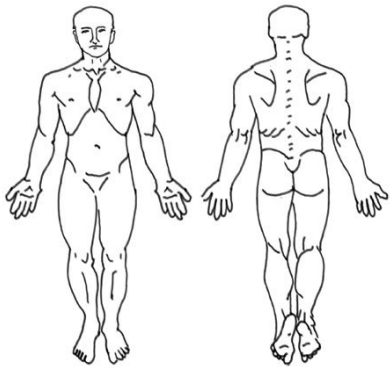
Current List of medications:

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 Disease	☐ Yes ☐ No	Allergies	☐ Yes ☐ No	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 weight loss/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/cold	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Depression/Anxiety	☐ Yes ☐ No	Vision/hearing difficulty	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Have you smoked	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Unusual Fatigue	☐ Yes ☐ No		☐ Yes ☐ No