



MEDICAL HISTORY QUESTIONNAIRE

Name (Last, First, M.I.):	Chosen Name/Nickname:
Pronouns: <input type="checkbox"/> She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> They/Them <input type="checkbox"/> Other	DOB:
Doctor:	Reason For Visit

PERSONAL HEALTH HISTORY

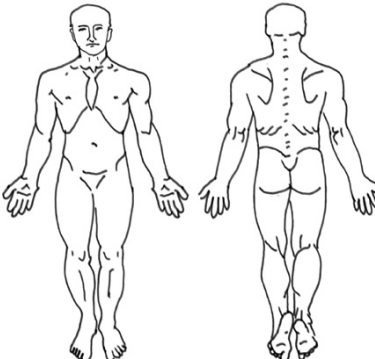
INJURY: <input type="checkbox"/> Work related <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Previous injury/exacerbation <input type="checkbox"/> Athletic related <input type="checkbox"/> Post Surgical (DATE:) <input type="checkbox"/> Other	DATE OF INJURY? Have you been treated for this condition previously: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please explain	Do you currently exercise? Are you allergic to Latex <input type="checkbox"/> Yes <input type="checkbox"/> No Are you currently working: What is your occupation? Hours per week? Estimated return to work <input type="checkbox"/> Yes <input type="checkbox"/> No
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List any medical problems that other doctors have diagnosed

Current List of medications:

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

PAIN SCALE: PLEASE RATE YOUR PAIN

CURRENTLY	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	X-burning O-tingling N-numbness **-throbbing +-stiffness //-aching	
AT WORST	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10		
AT BEST	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10		
Do you have frequent falls?	<input type="checkbox"/> Yes <input type="checkbox"/> No How Often?		
Could you be pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have a bleeding disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

MEDICAL HISTORY

Heart Attack or Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Taking blood thinners	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Changes in Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Changes in Bowel	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metal implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent weight loss/gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness/Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ehlers Danlos	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat/cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression/Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision/hearing difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you smoked	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unusual Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No