Medical History Form

NAME: ______________________OCCUPATION: ___________________ AGE: ______

DATE OF ONSET: Injury/Problem/Surgery: _____________________________________

Briefly state previous treatment, if any: ____

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Do you have now, or have you ever had, any of the following?

DIABETES	YES__NO__	ALLERGY TO COLD	YES__NO__
HIGH BLOOD PRESSURE	YES__NO__	OTHER ALLERGIES	YES__NO__
PACEMAKER	YES__NO__	PREVIOUS SURGERY	YES__NO__
CHRONIC HEADACHES	YES__NO__	SEIZURES	YES__NO__
KIDNEY PROBLEMS	YES__NO__	METAL IMPLANTS	YES__NO__
NERVOUS DISORDERS	YES__NO__	DIZZINESS	YES__NO__
HERNIA	YES__NO__	CANCER	YES__NO__
ALLERGY TO HEAT	YES__NO__	PREGNANT	YES__NO__
BONE DISEASE	YES__NO__	OSTEOPOROSIS	YES__NO__
FRACTURES	YES__NO__	BOWEL PROBLEMS	YES__NO__
BLADDER PROBLEMS	YES__NO__	RECENT WEIGHT LOSS	YES__NO__
PINS & NEEDLES	YES__NO__	CIRCULATORY DISEASE	YES__NO__
PROBLEMS WITH BOTH ARMS OR BOTH LEGS AT THE SAME TIME			YES__NO__

If YES to any of the above, please explain and give appropriate details:

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Are you presently taking any medications? YES__NO__
If YES, please complete the Medication List form.

Have you had any X-Rays, CAT scans, MRIs, or other diagnostic tests for your recent disorder?

YES__NO__ if YES, please explain the findings as you understand them:

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Is there anything else you think I should know about your general health, or current condition?

Please explain and, if necessary, we can talk about it:

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