



Confidential Medical History Form

Patient Name: _____ Date of Birth: _____ Referring MD: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

SS# (For insurance purposes only): _____ Occupation: _____

Is this injury work related? Yes No Is this injury related to a motor vehicle accident? Yes No
(Please answer the above by circling a response)

Chief Complaint: _____

DATE OF ONSET OR INJURY: _____ Did you have surgery for this problem? Yes No

If so, what was the date of the surgery? _____

Please list past surgeries: _____

List any/all medications your are currently taking: _____

Have you had any diagnostic tests for this injury? MRI Xrays CT Scan Other: _____

Do you have any of the following?

Pain when performing the following activities?

	Yes	No		Mild	Moderate	Severe	Unable
Asthma, Bronchitis or Emphysema	_____	_____	Bending	_____	_____	_____	_____
Shortness of Breath/ Chest Pain	_____	_____	Care for Family	_____	_____	_____	_____
Coronary Heart Disease	_____	_____	Carrying Groceries	_____	_____	_____	_____
Do you have a Pacemaker	_____	_____	Change Positions	_____	_____	_____	_____
High Blood Pressure	_____	_____	Climbing Stairs	_____	_____	_____	_____
Heart Attack/ Heart Surgery	_____	_____	Driving	_____	_____	_____	_____
Stroke/TIA	_____	_____	Ext. Computer use	_____	_____	_____	_____
Blood Clots/DVT/Emboli	_____	_____	Eating	_____	_____	_____	_____
Epilepsy/Seizures	_____	_____	Household Chores	_____	_____	_____	_____
Thyroid Trouble/Goiter	_____	_____	Kneeling	_____	_____	_____	_____
Anemia	_____	_____	Lifting Children	_____	_____	_____	_____
Infectious Disease What _____	_____	_____	Lifting	_____	_____	_____	_____
Diabetes	_____	_____	Pet Care	_____	_____	_____	_____
Cancer/Chemo/Radiation When _____	_____	_____	Reading	_____	_____	_____	_____
Arthritis/Swollen Joints	_____	_____	Bathing	_____	_____	_____	_____
Osteoporosis	_____	_____	Dressing	_____	_____	_____	_____
Varicose Veins	_____	_____	Shaving	_____	_____	_____	_____
Gout	_____	_____	Sleep	_____	_____	_____	_____
Sleeping Difficulties	_____	_____	Sitting	_____	_____	_____	_____
Emotional/Psychological Problems	_____	_____	Standing	_____	_____	_____	_____
Bowel/Bladder Problems	_____	_____	Walking	_____	_____	_____	_____
Severe/Frequent Headaches	_____	_____	Yard Work	_____	_____	_____	_____
Vision/Hearing Difficulties	_____	_____	Sports	_____	_____	_____	_____
Dizziness/Faintness	_____	_____	Rec. Activities	_____	_____	_____	_____
Are you Pregnant?	_____	_____	Exercise Daily _____	_____	_____	Weekly _____	_____

Other Medical Conditions: _____

Are you Aware of your Diagnosis? Yes No Are you aware of your Prognosis? Yes No