

MEDICAL HISTORY QUESTIONNAIRE

	Name: Age: Date of Evaluation:										
Other Treatment (PT, Chiropractic, etc.): Date of Last Physical: Tests (X-rays, MRI, Bone Scan): Surgeries (include dates):	Weight:	Не	eight:_		Marital Status:			Gender:			
Care Self Family Self Family Self Family Self Family Self	Main Problem (How/V	When & 1	Pain/Sy	ymptom	ıs):						
Surgeries (include dates):	Other Treatment (PT,	, Chiropr	actic, o	etc.):							
Medications:	Date of Last Physical:			A	llergies:	<u> </u>					
Medications: Substitute MEDICAL SCREENING Circle YES or NO	Tests (X-rays, MRI, B	one Scan	ı):								
Circle YES or NO Self Family Fa	Surgeries (include dat	es):									
Circle YES or NO Have you or any immediate family member been told you have: Self Family Rember been told you have: Self Rember Rember been told you have: Self Rember been told you have: Stock Yes No Yes No Yes No Yes No Stroke Yes No Tuberculosis Yes No Yes No Allerjeis/Asthma Yes No Yes No Yes No Self Rember been told you have a history of: Allerjeis/Asthma Yes No Yes No Yes No Self Rember been told you have a history of: Allerjeis/Asthma Yes No Yes No Yes No Self Rember been told you have a history of: Allerjeis/Asthma Yes No Yes No Yes No Self Rember been told you have a history of: Allerjeis/Asthma Yes No Yes No Yes No Self Rember been told you have a history of the partial your health Yes No Yes No Self Rember been told you have a history of the partial your health Yes No Yes No Self Rember been told you have a history of the partial your health Yes No Yes No Self Rember been told you have a history of the partial your health Yes No Yes No Self Rember been told you have been told you have a history of the partial your health Yes No Yes No Self Rember been told you have a history of the partial your health Yes No Yes No Self Rember be not have you have a history of the partial your health Yes	Medications:										
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Cancer Yes No Yes No Diabetes Yes No Yes No No No No No No No N					,	e YES or NO)					
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Depressed Yes No Under stress Yes No		Yes	No								
Under stress Yes No	Depressed	Yes									
Have a pacemaker Yes No	Under stress	Yes	No								
	Have a pacemaker	Yes	No								
How are you sleeping at night? (check one) ()fine () moderate difficulty () only with medication											
Do you or have you smoked tobacco? (circle one) Yes / No - If yes: packs/day: # of years: last use:											
I currently have difficulty with (check all that apply): () driving () getting up from a chair ()walking ()bending at the waist Are your symptoms: (check one): () getting worse ()same () getting											
THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE:	THE ABOVE STATEM	ENTS AR	E TRU	J E TO T I	HE BEST	Г OF MY KNOWLEDGE:					
SIGNATURE: DATE:	SIGNATURE:					DATE:					