



MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Date of Evaluation: _____

Weight: _____ Height: _____ Marital Status: _____ Gender: _____

Main Problem (How/When & Pain/Symptoms): _____

Other Treatment (PT, Chiropractic, etc.): _____

Date of Last Physical: _____ Allergies: _____

Tests (X-rays, MRI, Bone Scan): _____

Surgeries (include dates): _____

Medications: _____

MEDICAL SCREENING

(Circle YES or NO)

Have you or any immediate family member been told you have:

	<u>Self</u>		<u>Family</u>			<u>Self</u>		<u>Family</u>	
	Yes	No	Yes	No		Yes	No	Yes	No
Cancer					Diabetes				
High Blood Pressure					Heart Disease				
Angina/Chest Pain					Stroke				
Osteoporosis					Tuberculosis				
Arthritis					Thyroid condition				

Do you have a history of:

Allergies/Asthma	Yes	No			Rheumatic Fever	Yes	No
Kidney Disease	Yes	No			Hepatitis	Yes	No
Seizures	Yes	No			Bronchitis	Yes	No
Headaches	Yes	No			Ulcers	Yes	No

In the past 3 months have you had or do you experience:

A change in your health	Yes	No			Nausea/vomiting	Yes	No
Fever/chills/sweats	Yes	No			Unexplained weight change	Yes	No
Numbness/tingling	Yes	No			Changes in appetite	Yes	No
Difficulty swallowing	Yes	No			Changes in bowel	Yes	No
Shortness of breath	Yes	No			Changes in bladder function	Yes	No
Dizziness	Yes	No			Upper respiratory infection	Yes	No
Urinary tract infection	Yes	No					

Are you currently:

Pregnant	Yes	No
Depressed	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 () getting worse () same () getting better

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE:

SIGNATURE: _____

DATE: _____