

MEDICAL HISTORY FORM

Last Name: _____ **First Name:** _____ **D.O.B.:** _____

Primary concern for today's appointment: _____

PRESENT INVOLVMENT IN ANY OTHER HEALTH CARE:

Chiropractic Physiotherapy Massage Osteopathy Other: _____

SOFT TISSUE AND JOINT (Problem areas)

Shoulder Hip Muscle weakness/soreness
 Arm/Elbow Leg/Knee Spine _____
 Hand/Wrist Ankle/Feet Neck Other: _____

LIFESTYLE

Exercise Cigarettes
 Alcohol (# of drinks per month: _____)
 Coffee/Tea Drug use Other: _____

HEALTH HISTORY – Please indicate all that you currently have or have had in the past:

General

Loss of consciousness
 Blackouts
 Fainting
 Dizziness
 Numbness/pain/tingling
 Bruising
 Headaches/Migraines
 Shortness of Breath
 Loss of sleep
 Loss of weight
 Depression and/or anxiety
 Fatigue
 Joint Instability
 Hearing/Vision Loss
 Loss of Sensation
 Autoimmune disorder

Cardiovascular

High blood pressure
 Low blood pressure
 Heart Attack/Stroke
 Rapid heartbeat
 Pace Maker
 Chest Pain
 Heart murmur
 Buerger's Disease
 Anaphylactic Shock
 Poor circulation
 Aneurysms
 Hemophilia
 Varicose/Spider Veins
 Thrombosis
 Chest pains
 Phlebitis

Muscles & Joints

Fibromyalgia/Polymylgia
 Ankylosing Spondylitis
 Scoliosis
 Arthritis
 Osteoarthritis
 Rheumatoid Arthritis
 Reiter's Syndrome
 Swollen joints

Skin

Hives/Boils
 Skin Irritation/ itching
 Eczema/psoriasis
 Bruise easily
 Infectious skin condition
 Scleroderma

Other Conditions

Epilepsy
 Anemia
 History of cancer
 Lupus
 Hepatitis
 Hernia
 Diabetes Type 1 2
 Parkinson's
 Gout
 HIV/Aids
 Multiple Sclerosis
 Flaccid Paralysis
 History of seizures
 Osteoporosis
 Thyroid problems
 Ulcers

Respiratory

Asthma Chronic Cough Chronic Obstructive Pulmonary Disease (COPD) Sleep
 Bronchitis Emphysema Immunological disease Breathing difficulty Tuberculosis Cystic Fibrosis

Other

Pins/Plates/Wires (please specify location: _____) Allergies (please specify _____) Undiagnosed Lump
 Pelvic Inflammatory Disease Cosmetic Implants Currently pregnant (Due date: _____) Endometriosis
 Chronic Kidney Disease Difficulty swallowing Neuritis (swollen nerve)
 Other genetic disorder (please specify: _____) Bladder dysfunction Bowel dysfunction

Other (please specify): _____

Current Medication(s) (dosages and reason): _____

PAST SURGERIES OR INJURIES:

DATE

TREATMENT RECEIVED

All information is confidential and will not be released without your written consent.

I certify that the information in this form is true and accurately reflects my past and present health status:

Patient/Guardian (Please Print Name)

Signature

Date

