PATIENT HISTORY

Name: ______________________ Sex:________ Date of Birth: __________

Please complete all requested information.

1. Have you *ever* had?: (If Yes, please explain)

High Blood Pressure	No	Yes	______________________
Heart or Circulation Disorders	No	Yes	______________________
Seizures	No	Yes	______________________
Diabetes	No	Yes	______________________
Cancer	No	Yes	______________________
Arthritis/Osteoarthritis	No	Yes	______________________
Osteoporosis	No	Yes	______________________
Immune Deficiency Disease	No	Yes	______________________
Other	No	Yes	______________________

2. Please list surgeries you have had; please give procedures and dates, if possible: ______________________

3. Please list recent diagnostic studies (Cat-scan, MRI, X-rays): ______________________

4. Do you have any METAL anywhere in your body; pins/plates post fracture, or pacemaker (other th teeth)? No-Yes. Describe: ______________________

5. (For women only) Are you now pregnant? No - Yes. Date of last Menstrual cycle: ___/___/

6. Do you have any abnormal trouble with vision? No - Yes / Hearing? No - Yes

7. List any Allergies you have: ______________________

8. Have you ever taken steroids or anti-coagulants for an extended period of time? No - Yes

9. Have you had an unusual weight gain or loss lately? No - Yes

10. List medications you are now taking: ______________________

11. Have you ever had physical therapy treatments before? No - Yes
    If Yes, please indicate where, when, and for what problem: ______________________

12. Describe briefly the history of your present ACCIDENT, INJURY OR ILLNESS:
    Onset date: __________ Describe Onset: ______________________

13. Date of next Doctor appointment: ___/___/___

____
Patient Signature Date