

PAST MEDICAL HISTORY FORM

Name: _____ Date: _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: _____ Height: _____ Weight: _____
Are you on a work restriction from your doctor? Yes No Are you latex sensitive? Yes No
Do you smoke? Yes No Do you have a pacemaker? Yes No
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
If yes, when is your due date? _____

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> constipation |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> fainting |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough |
| <input type="checkbox"/> falls | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> headaches |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> lung problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> other arthritic condition | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke | <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> bone or joint infection | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> pneumonia |

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots |

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any medications, supplements or hormones you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? YES NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: Getting Better Getting Worse Staying about the same

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: Yes No When _____ Treatment rec'd _____

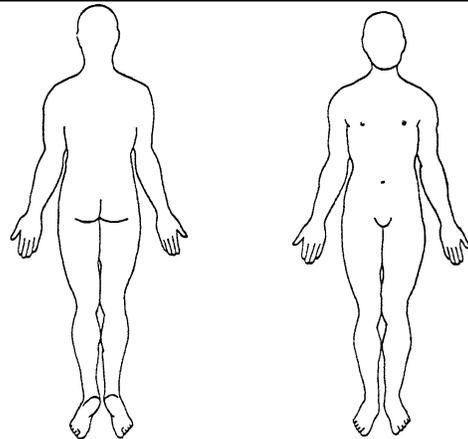
How long did it take for you to feel better? _____

If you have pain, please fill out below:

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling



My symptoms currently: Come and go Are Constant Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms the best? Morning Afternoon Evening Night After exercise

Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past week: _____

The worst your pain has been during the past week: _____

Patient Signature _____ **Date** _____

OR Parent/Guardian signature