PERSONAL MEDICAL HISTORY QUESTIONNAIRE

NAME:_____ DATE:_____

Please help us to identify your medical needs by carefully completing the following medical history questionnaire. If you have been diagnosed with any medical conditions from the following list, please circle it, indicate the date of onset, and make notations in the current status column.

CONDITION	DATE OF ONSET	CURRENT STATUS
Seizures		
Diabetes		
Hypoglycemia		
High Blood Pressure		
Heart Disease		
Angina/Chest Pain		
Shortness of Breath		
Stroke		
Allergies		
Asthma		
Rheumatic fever		
Hepatitis/Jaundice		
CHRONIC Bronchitis		
Pneumonia		
Emphysema		
Migraine Headaches		
Anemia		
Ulcers/Stomach Problems		
Arthritis/Gout		
Cancer (self or family)		
Vision Problems		
Muscle/Bone Injuries		
Nerve Injuries		

OTHER:_____

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PERSONAL MEDICAL HISTORY QUESTIONNAIRE (CONT.)

1. Why are you seeking treatment?

2. Are you pregnant?

3. Please list any current medications; PRESCRIBED and OVER-THE-COUNTER:

4. Has an X-ray, CT scan, MRI, or EMG been performed for this injury? Where/When?

5. Please list any surgeries and dates performed:

6. Do you have any metal hardware in your body?

7. Are there any other medical concerns we should know about?

Signature _____ Date _____

I understand and consent to the evaluation the treatment for physical therapy and body work. I reserve the right to refuse any and all treatment verbally at any time and will document it in writing.

_____ _____

Signature Date