



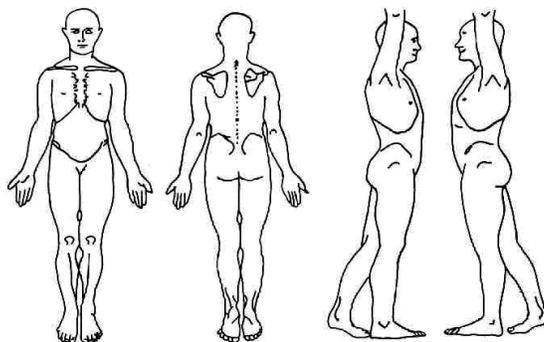
# Patient History

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Gender: Male  Female  Other  Age: \_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Are you currently working? Yes  No  Full-time  Part-time  Student

**Current Symptoms:** Please mark your affected area on the diagram using: XXXX = pain, 0000 = tingling/numbness



Date of Onset/Injury (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Briefly describe how and when you current symptoms began: \_\_\_\_\_

Are you currently being treated by:  
Another Therapist: Yes  No  Or within the last 12 months? Yes  No   
Chiropractor/ Osteopath: Yes  No  Or within the last 12 months? Yes  No   
Home Health Agency: Yes  No  Or within the last 12 months? Yes  No

Date of last MD visit pertaining to current injury: \_\_\_\_\_ Next scheduled visit with referring MD: \_\_\_\_\_

Have you had any previous injury or surgery to this related region: Yes  No

If yes, please explain and provide dates: \_\_\_\_\_

**Medical History:** Please check if you have ever had (check all that apply):

- Dizziness     Numbness     Circulation Problems     Gout     Cancer (location \_\_\_\_\_)
- Diabetes     Pacemaker     Currently Pregnant     Allergies     Tumors (location \_\_\_\_\_)
- Seizures     Arthritis     Heart Disease     Heart Attack     Cardiac Condition (explain \_\_\_\_\_)
- Osteoporosis     Hernia     Shortness of Breath     Stroke     Neurological Disorders (i.e. MS, ALS)
- Headaches     Loss of Balance     Infectious Disease     High or Low Blood Pressure
- Metal Implants     Difficulty Sleeping     Pain with Cough/Sneeze     Bowel/Bladder Changes
- Peripheral Vascular Disease     Asthma     Other (explain \_\_\_\_\_)

Major surgeries since birth (date/procedure): \_\_\_\_\_

