

## Confidential Medical History

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Marital Status (Circle): M S D W

Occupation: \_\_\_\_\_ Are you presently working? Y\_\_ N\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_

Name of Card Holder: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_

### Have you received any of the following services during your current insurance plan year?

Occupational Therapy	Y__ N__	Massage Therapy	Y__ N__
Physical Therapy	Y__ N__	Chiropractic Services	Y__ N__
Speech Therapy	Y__ N__	Home Health Services	Y__ N__

### Do you have any of the following medical conditions?

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	_____	_____	Osteoporosis	_____	_____
Shortness of Breath or Chest Pain	_____	_____	Varicose Veins	_____	_____
Coronary Heart Disease	_____	_____	Bowel or Bladder Problems	_____	_____
Pacemaker	_____	_____	Sleeping Difficulties	_____	_____
High Blood Pressure	_____	_____	Emotional or Psychological Problems	_____	_____
Heart Attack or Surgery	_____	_____	Severe or Frequent Headaches	_____	_____
Stroke or TIA	_____	_____	Vision or Hearing Difficulties	_____	_____
Blood Clot or Emboli	_____	_____	Dizziness or Faintness	_____	_____
Epilepsy or Seizures	_____	_____	Pregnancy	_____	_____
Thyroid Trouble or Goiter	_____	_____	Arthritis or Swollen Joints	_____	_____
Cancer or Chemotherapy/Radiation	_____	_____	Gout	_____	_____
Anemia	_____	_____	Other Medical Conditions:	_____	
Infectious Diseases	_____	_____		_____	
Diabetes	_____	_____		_____	

Referring Physician: \_\_\_\_\_ Referral Date: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Current Symptoms: Pain Numbness Stiffness Weakness Other: \_\_\_\_\_

List all medications you are currently taking:  None \_\_\_\_\_

List any known allergies:  None \_\_\_\_\_

List any previous surgeries:  None \_\_\_\_\_

Have you had any diagnostic imaging for this injury?  None MRI XRAYs CT SCAN Other: \_\_\_\_\_

Do you smoke? Y\_\_ N\_\_ How much/often? \_\_\_\_\_

Do you consume alcohol? Y\_\_ N\_\_ How much/often? \_\_\_\_\_

Do you exercise regularly? Y\_\_ N\_\_ How much/often? \_\_\_\_\_