

Medical History

Patient Name: _____ Date: _____

Describe any previous treatment for the condition we are seeing you for today. _____

Do you have a previous injury or condition that may affect your treatment? _____

Are you experiencing any of the following? **(Circle)**

Weight Change / Fever / Chills / Night Sweats
Falls / Loss of Balance

Pregnancy Numbness/Tingling
Loss of Consciousness / Fainting

Please list any medications you are currently taking: _____

Do you exercise? Yes / No Do you wear glasses/contacts? Yes / No Do you use alcohol? Yes / No
Do you smoke? Yes / No Are you currently dieting? Yes / No Are you hard of hearing? Yes / No

Please mark **(X)** if you have or ever had any of the following?

- _____ Frequent Headaches
- _____ Asthma / Lung Disease
- _____ Sprains / Strains
- _____ Nervous Disorders
- _____ Broken Bones
- _____ Rheumatoid Arthritis
- _____ Surgeries
- _____ Kidney Problems
- _____ Shortness of Breath
- _____ Circulation Problems
- _____ Other allergies
- _____ Paralysis
- _____ Allergies to heat or ice
- _____ Anemia
- _____ Dizziness
- _____ Diabetes
- _____ Respiratory Problems
- _____ Cancer
- _____ Blood Pressure Problems
- _____ Seizures

Please explain and give approximate dates for any items indicated above:

Please diagram your symptoms on the body chart below:

Numbness/tingling: XXX Burning: OOO Sharp Pain: /// Aching: ===

