INTERNET FORM

Medical History Form

Patient Name:_____Account Number: _____

Height:_____ft_____in Weight:_____(pounds) Date of injury:_____

Diagnosis as stated to you by your physician: _____

How did this injury/ exacerbation occur? _____

Have you been hospitalized for the present condition? ☐Yes ☐No If Yes, date: _____

Have you had surgery for the present condition? ☐Yes ☐No If Yes, date: _____

If yes, surgery type:_____

Have you had any falls this past year? ☐Yes ☐No If Yes, how many?_____

Have you received previous treatment for this condition? ☐Yes ☐No If Yes, date: _____

If yes, please summarize:_____

Have you ever had any of the following? ☐EMG ☐CT SCAN ☐MYELOGRAM ☐MRI ☐XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Acquired Respiratory Distress Syndrome	☐Yes	☐No
Angina	☐Yes	☐No
Anxiety or Panic Disorders	☐Yes	☐No
Arthritis (RA, OA)	☐Yes	☐No
Asthma	☐Yes	☐No
Chronic Obstructive Pulmonary Disease (COPD)	☐Yes	☐No
Congestive Heart Failure (CHF)	☐Yes	☐No
Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain)	☐Yes	☐No
Depression	☐Yes	☐No
Diabetes	☐Yes	☐No
Emphysema	☐Yes	☐No
Hearing Impairment	☐Yes	☐No
Heart Attack	☐Yes	☐No
Multiple Sclerosis	☐Yes	☐No
Osteoporosis	☐Yes	☐No
Parkinson's Disease	☐Yes	☐No
Peripheral Vascular disease	☐Yes	☐No
Stroke or TIA	☐Yes	☐No
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	☐Yes	☐No
Visual Impairment (cataracts, glaucoma, macular degeneration)	☐Yes	☐No

Allergies	☐Yes	☐No
Headaches	☐Yes	☐No
Back Injury	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No
Bowel / Bladder Abnormalities	☐Yes	☐No
Cancer	☐Yes	☐No
Dizzy or Fainting Spells	☐Yes	☐No
Epilepsy or Seizure Disorder	☐Yes	☐No
Fracture	☐Yes	☐No
Hepatitis A, B, C	☐Yes	☐No
Hernia	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
HIV/AIDS	☐Yes	☐No
Hypoglycemia	☐Yes	☐No
Immunosuppressant Condition or Medication	☐Yes	☐No
Kidney Problems	☐Yes	☐No
Liver / Gallbladder Problems	☐Yes	☐No
Metal Implants	☐Yes	☐No
Nausea / Vomiting	☐Yes	☐No
Pacemaker	☐Yes	☐No
Defibrillator	☐Yes	☐No
Pregnancy	☐Yes	☐No
Ringing in Your Ears	☐Yes	☐No
Sexual Dysfunction	☐Yes	☐No
Skin Abnormalities	☐Yes	☐No
Smoking	☐Yes	☐No
Special Diet Guidelines	☐Yes	☐No
Tuberculosis	☐Yes	☐No

Please continue to 2nd page

INTERNET FORM

Medical History Form (page 2)

Patient Name:_____Account Number: _____

Are you on any medications? Click here if attached: ☐ Attached Please list (you may use reverse side):

_____

_____

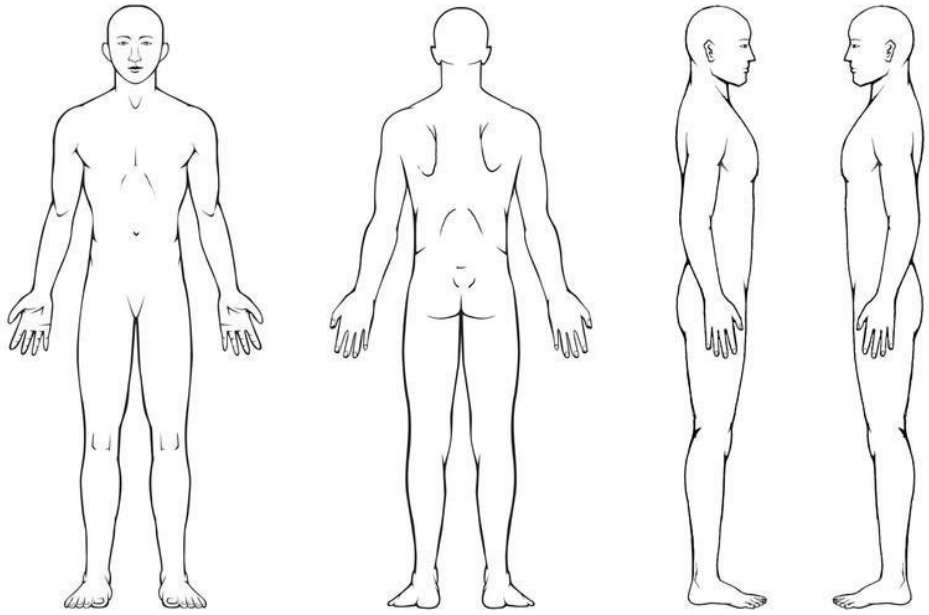
To help us understand your symptoms, please circle all that apply.

My pain is worse: in the morning☐during the day☐at night☐constant☐with activity☐during rest☐

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain at its best_____and at its worst_____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



Key

↑ or ↓ Radiating Pain
XXX Spasm
ZZZ Tenderness
//// Numbness/Tingling
000 Ache/Pain

Is there any other information regarding your medical history that we should know about? _____

_____

What is your goal for therapy at this time? _____

_____

Signature of Patient or Guardian (if patient is a minor):_____Date: _____