Medical History Questionnaire

Name: _____

Are you currently receiving home health or chiropractic services? No Yes _____
Home Health Agency

Have you had any imaging performed? No Yes X-Ray MRI CT Scan Doppler Ultrasound

List all medications: _____

Do you have any allergies? Yes No If yes, please list _____

PLEASE CIRCLE HEALTH PROBLEMS PAST OR PRESENT

Cardiac	Muscular	OB/GYN	Weight _____
Circulatory	Endocrine	Psychological	
High Blood Pressure	Digestive	Drug Dependency	Height _____
Diabetes	Bladder	Alcohol	
Respiratory	Bowel	Smoking	
Cancer	Headaches	Sleep Disorder	
Neurological	Dental	Swallowing Disorder	
Arthritis	Visual	Other_____	
Fractures	Communicable/Infectious Diseases _____		

Have you had any falls this year? Yes No _____

Do you have a pacemaker? Yes No Metal Implants? Yes No

Are you or could you be pregnant at this time? Yes No

Surgeries: list type and date _____

_____

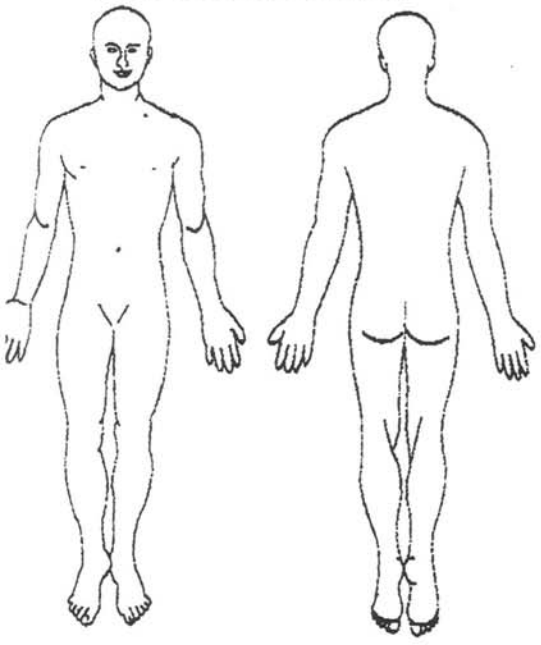
Have you ever received Physical, Occupational or Speech Therapy? Yes No

If so, for what type of problem? _____

What are your goals for treatment? _____

Are there any other considerations that your therapist should know? _____

Please mark the area of pain



Area and Behavior of Pain:

Initial site of pain _____

Where is the pain now? _____
(See diagram at left)

Rate your pain by circling a number:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Possible Pain

PATIENT SIGNATURE _____