Patient Name: _____ **Date:** _____

Medical History Information

Your injury is related to: Please Circle	**Work Car Accident Accident Other**
Injury occurred during? Please circle	**Lifting / Pulling / Pushing / Falling / Bending / Unknown / Other**
Onset Date:	
Any Diagnostic tests?	**Results:**
Height:	**Weight:**

Do you or an immediate relative have any history or issues pertaining to: (Check all that apply)

	YOU	RELATIVE	Describe ALL Responses that Directly Pertain to YOU
Vision or Hearing			
Lungs, Breathing, or Asthma			
Bowel/Bladder Incontinence			
Diabetes			
High Blood Pressure			
Bleeding Problems			
Balancing			
Numbness/Tingling			
Fainting			
Epilepsy/Seizures			
Chronic Headaches			
Psychological Problems			
ADHD/ Behavioral Problems			
Alzheimers Disease/Dementia			
HIV or AIDS			
Cancer			
Arthritis			
Hypoglycemia			
Heart Conditions			
Coronary Artery Disease			
Pacemaker			
Stroke, TIA, TBI			
Allergies			
Childhood Diseases			
Developmental delays			
Fractures			
Hospitalizations			
Surgeries			

SOCIAL HISTORY:

Are you currently preganant?	**YES**	**NO**	
Do you smoke?	**YES**	**NO**	
Do you consume alcohol?	**YES**	**NO**	

Additional Information: _____

_____

MEDICATIONS YOU CURRENTLY TAKE:

MEDICATION NAME:	REASON: