

MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (*Last, First, M.I.*): F M **DOB:**

Occupation:

Height: **Weight:** **Referring Doctors:** **Other Doctor:**

Chief complaint/ Reason for today's visit:

Pain : None 0 1 2 3 4 5 6 7 8 9 10 **Worst (Please Circle)**

PERSONAL HEALTH HISTORY

| | | | | |
|---------------------------------|------------------------------------|---|---|--|
| General Medical History: | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Polio | <input type="checkbox"/> Parkinson's Disease |
| | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Lupus | <input type="checkbox"/> Multiple Sclerosis |
| | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Skin Disease |
| | <input type="checkbox"/> Stroke | <input type="checkbox"/> Amputation(s) | <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Other |

Explain:

List all injuries related to your visit (sprains, fractures, falls, repetitive stress): **When**

| | | |
|------------------------|--|--|
| Head | | |
| Upper Extremity | | |
| Spine | | |
| Lower Extremity | | |
| Other | | |

Surgeries:

| Year | Reason | Hospital |
|------|--------|----------|
| | | |
| | | |
| | | |

| | |
|-----------------|--|
| Activity | <input type="checkbox"/> Sedentary (no exercise) |
| | <input type="checkbox"/> Mild exercise (i.e. climb stairs, walk 3 blocks, golf) |
| | <input type="checkbox"/> Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 min.) |
| | <input type="checkbox"/> Regular vigorous exercise (i.e. work or recreation 4x/week for at least 30 minutes) |