**General Information**

Today’s Date

Medical History

Patient Name:

1. Is this injury related to? ☐Work ☐ Car Accident☐ Other Liability/Potential Lawsuit ☐Not Applicable
2. Do you have a Primary Care Physician / Family Doctor? ☐No ☐Yes

If yes, have you had an appointment with him / her in the last 12 months? ☐No ☐Yes

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| --- | --- | --- |
| 3. Race/Ethnicity (Please select one): |  | |
| * Hispanic or Latino Origin | * Not Hispanic | * Asian or Pacific Islander |
| (includes Mexican, Cuban, Puerto Rican, | * African American | * Native American, Eskimo, or Aleutian |
| and other Latin American and Spanish) | * Caucasian (White) | * Other ☐Declined |

If you are a Medicare beneficiary, you are required by Medicare to answer the following question:

4. Do you consume more than 7 alcoholic drinks in a week? ☐ Yes ☐ No

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please Mark One Box For Each Item** | **No** | **Yes Under a year** | **Yes Over a year** | **No Answer**  **/Invalid** | **Please Mark One Box For Each Item** | **No** | **Yes Under a year** | **Yes Over a year** | **No Answer**  **/Invalid** |
| Smoking | ☐ | ☐ | ☐ | ☐ | Sexual dysfunction | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | Bladder / bowel problems | ☐ | ☐ | ☐ | ☐ |
| Heart condition | ☐ | ☐ | ☐ | ☐ | Groin numbness | ☐ | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ | ☐ | Arthritis | ☐ | ☐ | ☐ | ☐ |
| Chest pain | ☐ | ☐ | ☐ | ☐ | Osteoporosis | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | Psychological condition | ☐ | ☐ | ☐ | ☐ |
| Kidney condition | ☐ | ☐ | ☐ | ☐ | Seizures | ☐ | ☐ | ☐ | ☐ |
| Blood clot / DVT | ☐ | ☐ | ☐ | ☐ | Dizziness / faintness | ☐ | ☐ | ☐ | ☐ |
| Metal implants /  pacemaker | ☐ | ☐ | ☐ | ☐ | Ringing in ears | ☐ | ☐ | ☐ | ☐ |
| Breathing difficulties /  asthma | ☐ | ☐ | ☐ | ☐ | Allergy to latex (gloves) | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | Other allergy | ☐ | ☐ | ☐ | ☐ |
| Difficulty swallowing | ☐ | ☐ | ☐ | ☐ | Head Injury | ☐ | ☐ | ☐ | ☐ |
| Circulation/vascular  problems | ☐ | ☐ | ☐ | ☐ | Obesity | ☐ | ☐ | ☐ | ☐ |
| Peripheral neuropathy | ☐ | ☐ | ☐ | ☐ | Chronic pain/fibro/headaches | ☐ | ☐ | ☐ | ☐ |
| Unexplained weight loss | ☐ | ☐ | ☐ | ☐ | Fractures | ☐ | ☐ | ☐ | ☐ |
| Double vision | ☐ | ☐ | ☐ | ☐ | Infection | ☐ | ☐ | ☐ | ☐ |
| Night sweats / night pain | ☐ | ☐ | ☐ | ☐ | Fever / nausea | ☐ | ☐ | ☐ | ☐ |
|  |  |  |  |  | Are you pregnant? | ☐ | ☐ | ☐ | ☐ |

|  |  |  |  |
| --- | --- | --- | --- |
|  | No | Yes | If yes, please specify the condition |
| Infection Disease | ☐ | ☐ |  |
| Neurologic Condition (MS/Parkinson’s) | ☐ | ☐ |  |
| Pediatric Developmental Condition | ☐ | ☐ |  |
| Skin Disease | ☐ | ☐ |  |
| Spinal Cord Injury | ☐ | ☐ |  |
| Degenerative Joint Disease | ☐ | ☐ | * Spine☐ Upper Extremity ☐Lower Extremity |

**Patient Medication List**

# Please list ALL medications (including prescription, over –the-counter, vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

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| --- | --- | --- | --- |
| **Medication** | **Dosage** | **Frequency** | **Route of**  **Administration** |
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