PATIENT MEDICAL INFORMATION FORM

NAME ______________________________ OCCUPATION ________________ AGE ________________

CURRENT COMPLAINT ____

DATE OF ONSET OF: injury/surgery/problem ______________________________________

BRIEFLY STATE PREVIOUS TREATMENT, (IF ANY) ___________________________________

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Do you now have, or have you ever had, any of the following?

Diabetes	Yes____	No____	Allergy to cold	Yes____	No____
High Blood Pressure	Yes____	No____	Other allergies	Yes____	No____
Pacemaker	Yes____	No____	Previous Surgery	Yes____	No____
Chronic Headache	Yes____	No____	Seizures	Yes____	No____
Kidney Problems	Yes____	No____	Metal Implants	Yes____	No____
Nervous Disorders	Yes____	No____	Dizziness	Yes____	No____
Hernia	Yes____	No____	Cancer	Yes____	No____
Bone Disease/Fractures	Yes____	No____	Pregnant	Yes____	No____
Bowen/Bladder Problems	Yes____	No____	Osteoporosis	Yes____	No____
Pins and Needles	Yes____	No____	Recent weight loss	Yes____	No____
Circulatory Disease	Yes____	No____	Symptoms in both arms	Yes____	No____
Allergy to heat	Yes____	No____	and/or legs	Yes____	No____

If yes to any of the above, please explain and give appropriate details:

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Are you presently taking any medications? Yes____No____ If yes, please list what medications and for what condition(s):

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Have you had any X-rays, CAT scans, MRIs, or other diagnostic test for your recent disorder? Yes____No____

If yes, please explain the findings as you understand them:

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Is there anything else you think I should know about your general health? Please explain and if necessary, we can talk about it.

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Is there anyone that you do not authorize this information to be released to as it pertains to your treatment?

If so, please give their name(s). ____

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