

PAST MEDICAL HISTORY FORM

Name _____ Date _____

Are you presently working? Y N Date of next physician's visit _____

Date of injury/onset _____ Have you experienced these symptoms before? Y N

Cause of injury: Auto Work Sports Unknown Other: _____

If work comp, currently working? Y N Restrictions? Y N

Do you have or have you had any of the following:

Diabetes	Y N	Hypoglycemia	Y N	Osteoarthritis	Y N
Chest Pain	Y N	Osteoporosis	Y N	High Blood Pressure	Y N
Hernia	Y N	Heart Disease	Y N	Rheumatoid Arthritis	Y N
Pacemaker	Y N	Seizures	Y N	Headaches/Migraines	Y N
Metal Implants	Y N	Kidney Problems	Y N	Dizziness/Fainting	Y N
Cancer	Y N	Fractures	Y N	Pelvic Floor Pain	Y N
Blood Disorder	Y N	Head Injury	Y N	Incontinence	Y N
Fibromyalgia	Y N	Jaw Pain/TMD	Y N	Liver/Gallbladder Problems	Y N
Depression	Y N	Bipolar	Y N	Anxiety disorder	Y N
Stroke	Y N	Ringing in Ears	Y N	Asthma/Breathing Difficulty	Y N

If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

If female, are you pregnant? Y N Estimated Due Date: _____

Do you have any allergies? Y N If yes, please list _____

Are you presently taking any medication? Y N If yes, please list what medication and for what condition _____

Reviewed by therapist: _____ Date: _____