MEDICAL HISTORY FORM

Last Name: _____ **First Name**: _____ **D.O.B**: _____
Primary concern for today's appointment: _____

PRESENT INVOLVMENT IN ANY OTHER HEALTH CARE:
☐ Chiropractic ☐ Physiotherapy ☐ Massage ☐ Osteopathy ☐ Other:_____

SOFT TISSUE AND JOINT (Problem areas)
☐ Shoulder ☐ Hip ☐ Muscle weakness/soreness
☐ Arm/Elbow ☐ Leg/Knee ☐ Spine_____
☐ Hand/Wrist ☐ Ankle/Feet ☐ Neck ☐Other: _____

LIFESTYLE
☐ Exercise ☐ Cigarettes
☐ Alcohol (# of drinks per month:___)
☐ Coffee/Tea ☐ Drug use ☐ Other:_____

HEALTH HISTORY – Please indicate all that you currently have or have had in the past:

General	**Cardiovascular**	**Muscles & Joints**	**Other Conditions**
☐ Loss of consciousness	☐ High blood pressure	☐ Fibromyalgia/Polymylgia	☐ Epilepsy
☐ Blackouts	☐ Low blood pressure	☐ Ankylosing Spondylitis	☐ Anemia
☐ Fainting	☐ Heart Attack/Stroke	☐ Scoliosis	☐ History of cancer
☐ Dizziness	☐ Rapid heartbeat	☐ Arthritis	☐ Lupus
☐ Numbness/pain/tingling	☐ Pace Maker	☐ Osteoarthritis	☐ Hepatitis
☐ Bruising	☐ Chest Pain	☐ Rheumatoid Arthritis	☐ Hernia
☐ Headaches/Migraines	☐ Heart murmur	☐ Reiter's Syndrome	☐ Diabetes Type 1 ☐ 2☐
☐ Shortness of Breath	☐ Buerger's Disease	☐ Swollen joints	☐ Parkinson's
☐ Loss of sleep	☐ Anaphylactic Shock	**Skin**	☐ Gout
☐ Loss of weight	☐ Poor circulation	☐ Hives/Boils	☐ HIV/Aids
☐ Depression and/or anxiety	☐ Aneurysms	☐ Skin Irritation/ itching	☐ Multiple Sclerosis
☐ Fatigue	☐ Hemophilia	☐ Eczema/psoriasis	☐ Flaccid Paralysis
☐ Joint Instability	☐ Varicose/Spider Veins	☐ Bruise easily	☐ History of seizures
☐ Hearing/Vision Loss	☐ Thrombosis	☐ Infectious skin condition	☐Osteoporosis
☐ Loss of Sensation	☐ Chest pains	☐Scleroderma	☐Thyroid problems
☐ Autoimmune disorder	☐ Phlebitis		☐Ulcers

Respiratory
☐ Asthma ☐ Chronic Cough ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Sleep
☐ Bronchitis ☐ Emphysema ☐ Immunological disease ☐ Breathing difficulty ☐ Tuberculosis ☐ Cystic Fibrosis

Other
☐ Pins/Plates/Wires (please specify location:_____) ☐ Allergies (please specify_____) ☐ Undiagnosed Lump
☐ Pelvic Inflammatory Disease ☐ Cosmetic Implants ☐ Currently pregnant (Due date:_____) ☐ Endometriosis
☐ Chronic Kidney Disease ☐ Difficulty swallowing ☐ Neuritis (swollen nerve)
☐ Other genetic disorder (please specify:_____) ☐ Bladder dysfunction ☐ Bowel dysfunction

Other (please specify): _____
Current Medication(s) (dosages and reason): _____

PAST SURGERIES OR INJURIES:	**DATE**	**TREATMENT RECEIVED**
_____	_____	_____
_____	_____	_____

All information is confidential and will not be released without your written consent.
I certify that the information in this form is true and accurately reflects my past and present health status:

_____ _____ _____
Patient/Guardian (Please Print Name) Signature Date