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Medical History Form

| | | |
|----------------------|----------------------|----------------------|
| First Name | Last Name | M. I. |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Sex | Date | |
| <input type="text"/> | <input type="text"/> | |

In order for us to be more effective and specific with your treatment, we require that all sections below be filled out as completely as possible (even if you feel the information is non-applicable).

PATIENT INFORMATION

What are your current symptoms? What brought you here today?

| |
|----------------------|
| <input type="text"/> |
| <input type="text"/> |

Please list all injuries/accidents below

| Date | Type of Injury (sports, fracture, whiplash, falls, torn ligaments, etc) |
|----------------------|---|
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |

Please list all medical/structural diagnosis below

| Date | Type of Diagnosis (scoliosos, Lupus, etc) |
|----------------------|---|
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |

Please list all treatments below

| Date | Type of treatment (phys. therapy, massage, chiropractic, etc.) | (please circle result) |
|----------------------|--|------------------------|
| <input type="text"/> | <input type="text"/> | better same worse |
| <input type="text"/> | <input type="text"/> | better same worse |
| <input type="text"/> | <input type="text"/> | better same worse |
| <input type="text"/> | <input type="text"/> | better same worse |

How many children/pregnancies? (female patients only)

| Date | Type of birth (natural, c-section) |
|----------------------|------------------------------------|
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |

Please list all surgeries below

| Date | Procedure |
|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |

Please list all external braces below

| Date | Diagnosis (orthotics, dental splints, etc.) |
|----------------------|---|
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |

Please list all applicable family history information below

| Condition | Relationship | Age Developed, Diagnosis |
|----------------|----------------------|--------------------------|
| Cancers | <input type="text"/> | <input type="text"/> |
| Cardiovascular | <input type="text"/> | <input type="text"/> |
| Diabetes | <input type="text"/> | <input type="text"/> |
| Arthritis | <input type="text"/> | <input type="text"/> |
| Other | <input type="text"/> | <input type="text"/> |

Please list all medications below

| Medication | Condition |
|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |

Please list all hormones below

| Medication (Insulin, Premarin, etc.) | Condition (post-menopause, etc.) |
|--------------------------------------|----------------------------------|
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |