PAST MEDICAL HISTORY FORM

PATIENT NAME: _____DOB: _____DATE: _____

Do you have any barriers to learning? Yes ____ No____ If Yes", please list:_____

Problem(s) to be treated: _____

Have you had treatment for this problem before? Yes ____ No____

If "Yes", please list where: _____ Approximately when: _____

Have you had an X-ray, MRI, or other imaging study for this problem? Yes No
If "Yes", please list type of test: _____ Approximately when: _____
Have you had surgery associated with this problem? Yes No
If "Yes", please list type of surgery: _____ Approximately when: _____

Past Surgical History (type and date):

_____

List current medications: (or write "see copy" and provide list for us to copy)

_____

List any allergies (latex, drug, etc.):

_____

Are you pregnant? Yes No If "Yes", please list your due date: _____
Please circle each condition that you have been told you have (or had):

AIDS	Fibromyalgia	Liver Disease	Rheumatoid Arthritis
Allergies/Asthma	Heart Disease	Lung Disease	Seizures
Bleeding Disorder	Hepatitis	Lupus	Stroke
Cancer	High Blood Pressure	Osteoarthritis	
Diabetes	Kidney Disease	Osteoporosis	

Please circle any of the following you may have/wear:
Pacemaker Metal/Foreign Objects/Implants Dentures

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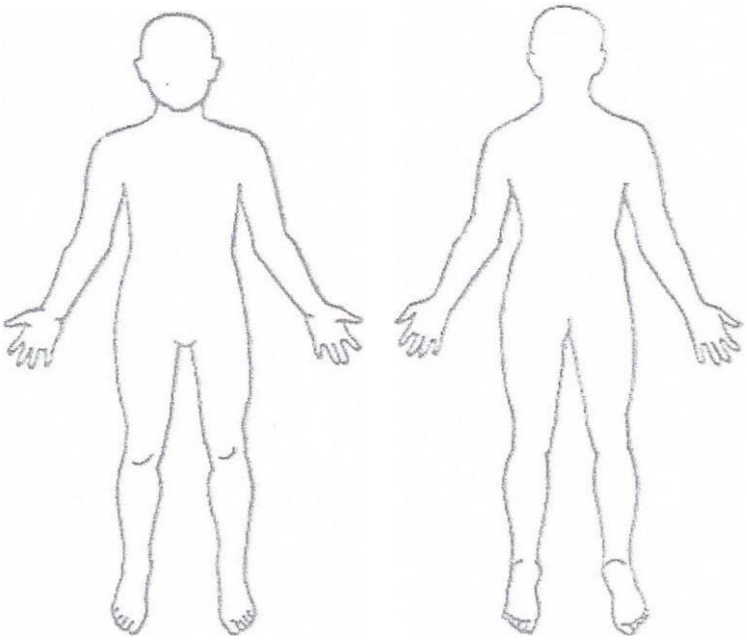
Please circle any symptoms you are currently experiencing:

Unexplained weight loss	Numbness/tingling	Changes in appetite
Depression	Shortness of breath	Dizziness
Changes in bowel/bladder	Nausea/Vomiting	Poor balance/falls
Fevers/chills/sweats	Headaches	Increased pain at night

What date (approximately) did your present pain start?
How (gradually, suddenly, resulting from injury)?
Are your symptoms currently (circle one): Getting better / About the same / Getting worse

Please mark the areas where you feel pain on the chart to the right:



Circle the number which best represents the average level of pain you have had over the last 48 hours:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Circle number which best represents your overall average level of function:

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 Able to do everything

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What are your personal goals for therapy at this time:

_____

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem(s):

1.
2.
3._____

CONSENT: To the best of my knowledge, the above information is true and correct. I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

Patient or Patient Representative's Signature: _____ Date: _____