Medical History

Today's Date:_____ Patient Name:_____

General Information

1. Is this injury related to? ☐ Work ☐ Car Accident ☐ Other Liability/Potential Lawsuit ☐ Not Applicable
2. Do you a Primary Care Physician/Family Doctor? ☐ No ☐ Yes
   If yes, have you had and appointment with him/her in the last 12 months? ☐ No ☐ Yes
3. race/Ethnicity (Please select one):

☐ Hispanic or Latino Origin (includes Mexican, Cuban, Puerto Rican, and other Latin American and Spanish) ☐ Not Hispanic ☐ African American ☐ Caucasian ☐ Asian or Pacific Islander ☐ Native American, Eskimo, or Aleutian ☐ Other ☐ Declined

if you are Medicare beneficiary, you are required by Medicare to answer the following question:

4. Do you consume more that 7 alcoholic drinks in a week? ☐ Yes ☐ No

Please Mark One Box For Each Item	No	yes Under a year	yes Over a year	No Answer /Invalid	Please Mark One Box For Each Item	No	yes Under a year	yes Over a year	No Answer /Invalid
Smoking	☐	☐	☐	☐	Sexual Dysfunction	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Bladder/Bowel Problems	☐	☐	☐	☐
Heart Condition	☐	☐	☐	☐	Groin Numbness	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	Arthritis	☐	☐	☐	☐
Chesr Pain	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	Psychological Condition	☐	☐	☐	☐
Kidney Condition	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
Blood Clot / DVT	☐	☐	☐	☐	Dizziness/Faintness	☐	☐	☐	☐
Metal Implants/pacemaker	☐	☐	☐	☐	Ringing in Ears	☐	☐	☐	☐
breathing Difficulties/Asthma	☐	☐	☐	☐	Allergy to Latex (gloves)	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Other Allergy	☐	☐	☐	☐
Difficulty Swallowing	☐	☐	☐	☐	Head Injury	☐	☐	☐	☐
Circulation/Vascular Problems	☐	☐	☐	☐	Obesity	☐	☐	☐	☐
Peripheral Neuropathy	☐	☐	☐	☐	Chronic Pain/Fibro/headaches	☐	☐	☐	☐
Unexplained Weight Loss	☐	☐	☐	☐	Fractures	☐	☐	☐	☐
Double Vision	☐	☐	☐	☐	Infection	☐	☐	☐	☐
Night Sweats/Night Pain	☐	☐	☐	☐	Are You Pregnant?	☐	☐	☐	☐

	No	Yes	If yes, Please specify the condition
Infection Disease	☐	☐	
Neurogical Condition (MS/parkinson's)	☐	☐	
Pediatric Developmental Condition	☐	☐	
Skin Disease	☐	☐	
Spinal Cord Injury	☐	☐	
Degenerative Joint Disease	☐	☐	☐ Spine ☐ Upper Extremity ☐ lower Extremity