FYI: Only patients allowed in gym.
No children left unattended in waiting room.
Please turn cell phones OFF

Medical History

Name | Referring Physician

Email Address:

Family Physician | Date of 1st Doctor Visit for this injury

/ / | / /

Last Date Worked due to this injury | Date due to return to work for this injury

Is an attorney involved in this case? Yes No
Have you had Surgery for this Injury? Yes No
If Yes, Where was your surgery Performed:

Are you currently Taking Medications Yes No
List Medications:

Have you had any of the following Medical or Rehabilitative services for this injury/episode?

	Yes	No		Yes	No
Chiropractor			CT Scan		
EMG/NCV			MRI		
Massage Therapy			General Practitioner		
Myelogram			Neurologist		
Occupational Therapy			Orthopedist		
Physical Therapy			Podiatrist		
Emergency Room Care			X-Rays		
Other Explain:					

Do you now have or have you ever had any of the following?

	Yes	No		Yes	No
Bronchitis, Asthma, Emphysema			Severe or frequent headaches		
Shortness of Breath/Chest pain			Vision / Hearing difficulties		
Coronary heart Disease or Angina			Numbness or tingling		
Do you have a Pacemaker			Dizziness or fainting		
High Blood Pressure			Bowel or bladder problems		
Heart Attack or Heart Surgery			Weakness		
Stroke / TIA			Weight loss / Energy loss		
Congestive Heart Disease			Hernia		
Blood Clot / Emboli			Varicose Veins		
Epilepsy / Seizures			Allergies		
Thyroid Disease or Goiter			Any pins or metal implants		
Anemia			Joint replacement surgery		
Infectious Diseases			Neck injury / surgery		
Diabetes			Shoulder injury / surgery		
Cancer /Chemotherapy / Radiation			Elbow / hand injury / surgery		
Arthritis			Back injury / surgery		
Osteoporosis			Knee Injury / surgery		
Gout			Leg / ankle / foot injury / surgery		
Sleeping Problems / Difficulties			Are you pregnant		
Emotional / Psychological Problems			Do you use tobacco		

List any other information that would assist us in your care:
____

Are you aware of your diagnosis? Yes No Based on your awareness, what are you rehabilitation expectation / goals?
____

Patient / Guardian Signature_______________________________ Date: ____/_____/_____