MEDICAL HISTORY INFORMATION FORM **Date** ________________

NAME ____ **AGE** _________________

DATE OF ONSET—injury/surgery/problem ____

EMERGENCY CONTACT (name/phone) ____

BRIEFLY LIST PREVIOUS TREATMENT FOR THIS CONDITION ______________________

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

DIABETES	YES/NO	PRIOR SURGERY	YES/NO
HIGH BLOOD PRESSURE	YES/NO	ARE YOU PREGNANT?	YES/NO
PACEMAKER	YES/NO	METAL IMPLANTS	YES/NO
CIRCULATORY DISEASE	YES/NO	CANCER	YES/NO
KIDNEY PROBLEMS	YES/NO	OSTEOPOROSIS	YES/NO
RESPIRATORY PROBS	YES/NO	CONTACT LENSES	YES/NO
EPILEPSY/SEIZURES	YES/NO	DENTURES	YES/NO
HERNIA	YES/NO	GRIND TEETH	YES/NO
BROKEN BONES	YES/NO	DIZZINESS	YES/NO
BOWEL/BLADDER ISSUES	YES/NO	RECENT WEIGHT LOSS	YES/NO
PINS/NEEDLES/NUMBNESS	YES/NO	CHRONIC PAIN	YES/NO
CHRONIC HEADACHES	YES/NO	FREQUENT STRESS	YES/NO

If YES to any of the above, please provide appropriate details: __________________________

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Are you presently taking any medications? YES/NO If YES, please list. _________________

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List any allergies you have. ____

Have you had any X-rays, CAT scans, MRI's, nerve studies or any other diagnostics for you disorder? List and explain the findings as you understand them. _________________________

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Is there anything else you think I should know about your general health? Please explain and, if necessary, we can talk about it. ____

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