MEDICAL HISTORY QUESTIONNAIRE

1.) What is your reason for seeking treatment (If more than one reason, please list in order of importance?

_____

_____

2.) Date of injury/surgery/beginning of symptoms? _____

3.) Do you have any problems with:

   a. Allergies? NO / YES:_____

   b. Heart Condition? NO / YES:_____

   c. Seizure Disorder? NO / YES:_____

   d. Diabetes? NO / YES Hypoglycemia? NO / YES

4.) Are you pregnant? NO / YES What Trimester? _____

5.) Who is your primary care physician? (first and last name)_____

6.) Have you sought treatment elsewhere for this problem? Chiropractic/P.T./Massage/Other

_____

7.) What are your goals?_____

8.) Is this injury related to a(n): **(please circle one)** **N/A** or **Motor Vehicle Accident (MVA)** or **Industrial (Work)**

How did injury occur? _____

Date of injury: _____ Was another party responsible? YES / NO

9.) Please list any current medications:

_____

_____

10.) Please list any pertinent family history of medical problems (i.e. mother has osteoporosis; grandfather had knee replacement due to arthritis):

_____

_____

_____ _____ _____

Patient Name (Print) Patient/Guardian Signature Date

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