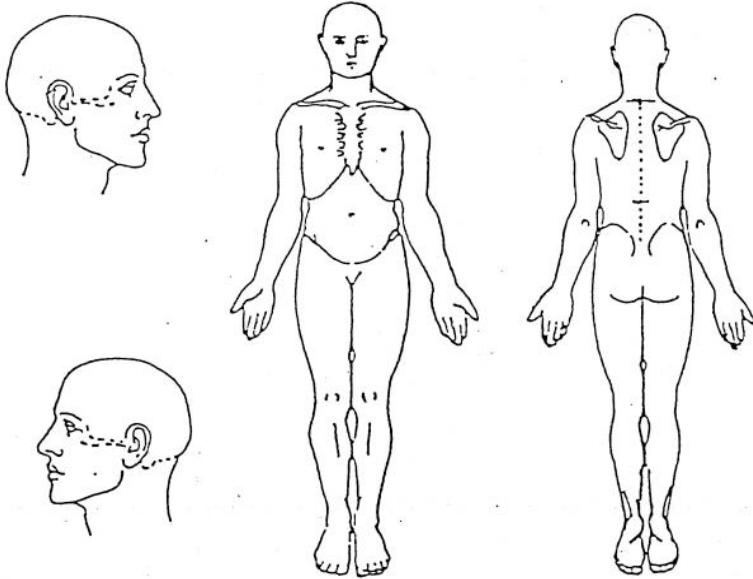


MEDICAL HISTORY FORM

Name _____ Date _____

Birth date _____ Email _____

Please mark the appropriate area of the diagram to show the location of your current symptoms:



Please describe your current symptoms:

Date of injury/surgery: _____

How did your symptoms begin?

Have you used any other forms of treatment for your current problem: (i.e. chiropractor, PT, acupuncture, etc.)?

Please List All Orthopedic or Abdominal Operations/Surgeries:

Operation Performed	Year
_____	_____
_____	_____
_____	_____
_____	_____

List the medications you are now taking:

List any allergies you have to drugs, food or other items (including latex):

Pain Level: (0 being none and 10 being the worst)

0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms feel better? _____

What makes your symptoms feel worse? _____

Stress Level: (0 being none and 10 being the worst)

0 1 2 3 4 5 6 7 8 9 10

Do you exercise? Yes No

• **If yes, what type of exercise?** _____

• **How often?** _____

Have you had any of the following illnesses: (Please Circle)

High Blood Pressure

Cancer

Crohn's Disease

Diabetes (type I or II)

Multiple Chemical Sensitivity

Elevated Heart Rate

Thyroid Dysfunction

Candida (yeast allergy)

Adrenal Fatigue

High Cholesterol

Eating Disorder

Restless Leg Syndrome

Heart Attack/Disease

Celiac Disease

Pacemaker

Asthma

Migraine Headaches

Headaches, if yes, how often?

Pulmonary Diseases

Alcoholism

Osteoporosis

Stroke

Anxiety

Osteopenia

Brain injury

Sleep Disorders

Chronic Pain

Blood clots

Irritable Bowel Syndrome

Fibromyalgia

Mental Illness/Depression

Ulcers

Dysautonomia

Arthritis

PTSD

Sensory Processing Disorder

Interstitial Cystitis

Chronic Pelvic Pain

Other serious illnesses: (please explain):

Signature (parent/guardian signature if patient is a minor)

Date