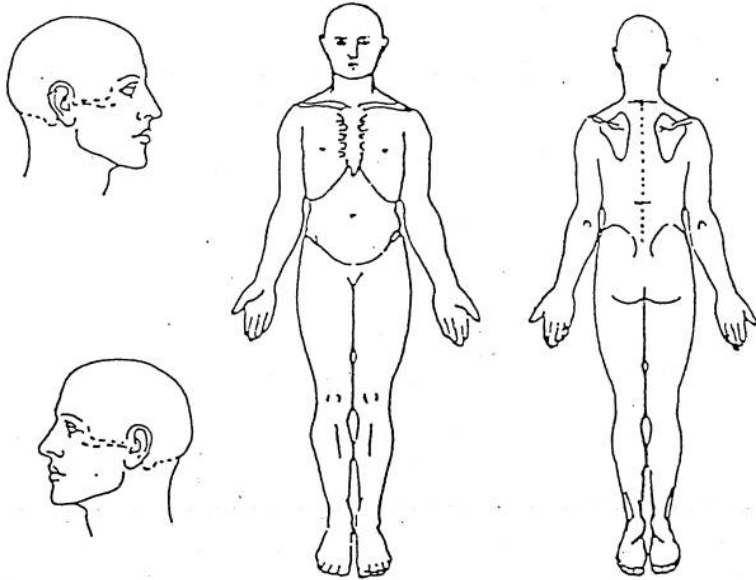


MEDICAL HISTORY FORM

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	Diabetes (type I or II)	Thyroid Dysfunction
High Cholesterol	Heart Attack/Disease	Asthma
Pulmonary Diseases	Stroke	Brain injury
Blood Clots	Mental Illness/Depression	Arthritis
Cancer	Multiple Chemical Sensitivity	Candida (yeast allergy)
Eating Disorder	Celiac Disease	Migraine Headaches
Alcoholism	Anxiety	Sleep Disorders
Irritable Bowel Syndrome	Ulcers	PTSD
Crohn's Disease	Elevated Heart Rate	Adrenal Fatigue
Restless Leg Syndrome	Pacemaker	Headaches, if yes, how often?
Osteoporosis	Osteopenia	Other serious illness (please explain):

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

Date