Date:_____ Patient Name:_____

PATIENT MEDICAL HISTORY

1. **Which of the following *best describes* your condition?** (if your condition is post surgical please indicate as per original condition)

☐ lifting process	☐ degenerative
☐ a fall	☐ unknown
☐ an incident at work	☐

other_____
☐ overuse (cumulative trauma)
☐ during recreation/sports _____
☐ MVA (car accident) State accident occurred ____ Driver/Passenger if MVA (circle one)

∗Onset Date of Symptoms _____/_____/_____

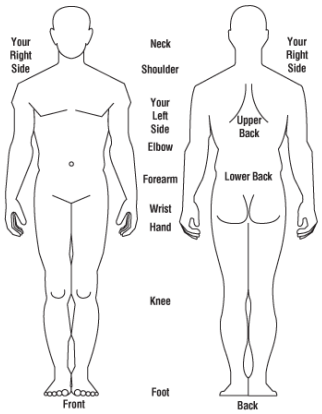
∗Surgery Date if applicable_____/_____/_____

2. **Nature of primary complaint** (check all that apply):

☐ pain	☐ numbness/tingling	☐ sharp
☐ aching	☐ constant	☐ dull
☐ burning	☐ weakness	☐

other_____
☐ throbbing ☐ intermittent

Using the key, please indicate on the body diagram where your symptoms are located:
X = Pain O = Tingling // = Numbness



3. **Please check any other health care providers you are <u>currently</u> seeing for this condition:**
☐ None ☐ MD_____ ☐ Dentist
☐ Podiatrist ☐ Chiropractor ☐ Physical Therapist

4. **Please check if you have had any of the following:**
☐ EMG ☐ XRAY ☐ MRI ☐ CT SCAN

5. **If retired, permanently disabled, or unemployed, skip to section 6.**

Physical activities at work:

☐ sitting	☐ standing	☐ computer use
☐ phone use	☐ repetitive lifting	☐ driving
☐ heavy lifting	☐ walking	
☐ crawling	☐ heavy equipment operation	
☐ bending		

<u>If not performing your normal activities at work</u>, do you plan to return to your previous activity level? ☐ Yes ☐ No

<u>If you were injured on the job</u>, please describe how the incident occurred.

_____
_____
_____
_____
_____
_____.

6. **Please list ALL prescriptions, over the counter medications, herbal supplements, and vitamins you are currently taking with dosage, frequency, and route of administration (oral, injection, inhalation, etc.):** ☐ see attached list

Name	Dosage	Frequency	Route of Administration

7. **Please list any allergies you have _____**
_____
_____

8. **Please list any surgeries you have had _____**
_____
_____
_____
_____
_____

9. **Please list your therapy goals:**
_____
_____
_____

Patient/Guardian Signature:_____