

- Medical History -

Name: _____ Account #: _____ Date: _____
Date of birth and age: _____

Date last seen by your Physician for this condition? _____
Have you been treated this year by a physical or speech therapist? _____
Have you been treated this year by an acupuncturist or chiropractor? _____
Have you been discharged from a home care agency in the last 30 days? _____
Are you currently receiving other care for this condition? _____
At the present time, would you say that your health is: _____excellent _____very good _____fair _____poor?

Please mark the medical conditions that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer-type _____ | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Broken Bones/Fracture | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Stroke | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Circulatory / Vascular Problems | <input type="checkbox"/> Diabetes / High Blood Sugar | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Low Blood Sugar / Hypoglycemia | <input type="checkbox"/> Prostate Conditions |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Neurological Problems |
| | | <input type="checkbox"/> Depression |

Other (please describe): _____

Allergies (list): _____

Medications (list): _____

Recent Medical Testing: _____

Surgeries (include date): _____

Do you have metal/hardware in your body as a result of surgery? _____

Have you experienced any of the following symptoms during the last year?

- | | | |
|---|--|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pain at Night | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Weight Loss or Gain |
| <input type="checkbox"/> Dizziness or Blackouts | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Coordination Problems |
| <input type="checkbox"/> Joint Pain or Swelling | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Weakness in Arms or Legs |