

Patient Injury / Health History

Name _____ **Onset of Injury / Pain** ____/____/____
Diagnosis _____ **Date of Surgery** ____/____/____
Next Physician Appt ____/____/____

In your words, please explain your injury / illness and why you are here today _____

- Yes No Are you currently playing sports / working?
Employer _____ Job Title: _____
Type of sport(s) / recreation _____
- Yes No Is this the first injury / pain to this body part?
If no, please explain _____
- Yes No Are you currently receiving treatment(s) for this injury / pain?
If yes, please explain _____
- Yes No Have you had previous treatment(s) for this injury / pain? Including X-ray or MRI
If yes, please explain _____
- Yes No Do you have any physical obstacles to your activities of daily life not related to this injury?
If yes, please explain _____
- Yes No Do you currently take any medications?
If yes, please list _____
- _____
- Yes No Have you had any previous surgeries?
If yes, please explain _____

Have you had or do you now have any of the following? (Please circle Yes or No)

condition	Yes	No	year
back pain / injury	Yes	No	
arthritis	Yes	No	
fainting or dizzy spells	Yes	No	
frequent headaches or migraines	Yes	No	
epilepsy / seizures	Yes	No	
heart disease	Yes	No	
high / low blood pressure	Yes	No	
stroke / transient ischemic attack	Yes	No	
mental impairments	Yes	No	
please list			
allergies	Yes	No	
please list			

condition	Yes	No	year
osteoporosis / osteopenia	Yes	No	
pacemaker	Yes	No	
neurotransmitter implant	Yes	No	
peripheral arterial disease	Yes	No	
diabetes / low blood sugar	Yes	No	
lung disease / shortness of breath	Yes	No	
Cancer	Yes	No	
autoimmune disease	Yes	No	
hernia(s)	Yes	No	
Any chance of pregnancy?	Yes	No	
Have you smoked in the past year?	Yes	No	
Would you like information on smoking cessation?	Yes	No	

