Confidential Medical History

Name: _____ **Date of Birth** _____/_____/_____ **SS#:** _____

Address: _____ **City/State/Zip:** _____

Phone: _____ **Cell:** _____ **E-mail:** _____

Emergency Contact & Phone #: _____

Marital Status (Circle): M S D W **Are you presently working? Y___ N___ Occupation:** _____

Employer: _____ **Employer Phone:** _____

Insurance Company: _____ **ID#:** _____

Name of Card Holder: _____ **Date of Birth** _____/_____/_____ **SS#:** _____

Card Holder's Employer: _____

Have you received any of the following services during your current insurance plan year?

Occupational Therapy	**Y___ N___**	**Massage Therapy**	**Y___ N___**
Physical Therapy	**Y___ N___**	**Chiropractic Services**	**Y___ N___**
Speech Therapy	**Y___ N___**	**Home Health Services**	**Y___ N___**

Do you have any of the following medical conditions?

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	_____	_____	**Osteoporosis**	_____	_____
Shortness of Breath or Chest Pain	_____	_____	**Arthritis or Swollen Joints**	_____	_____
Coronary Heart Disease	_____	_____	**Bowel or Bladder Problems**	_____	_____
Pacemaker	_____	_____	**Sleeping Difficulties**	_____	_____
High Blood Pressure	_____	_____	**Emotional or Psychological Problems**	_____	_____
Heart Attack or Surgery	_____	_____	**Severe or Frequent Headaches**	_____	_____
Stroke or TIA	_____	_____	**Vision or Hearing Difficulties**	_____	_____
Blood Clot or Emboli	_____	_____	**Dizziness or Faintness**	_____	_____
Epilepsy or Seizures	_____	_____	**Pregnancy**	_____	_____
Cancer or Chemotherapy/Radiation	_____	_____	**Gout**	_____	_____
Anemia	_____	_____			
Infectious Diseases	_____	_____	**Other Medical Conditions:** _____		
Diabetes	_____	_____	_____		

Referring Physician: _____ **Referral Date:** _____

Chief Complaint: _____ **Date of Injury:** _____

Current Symptoms: Pain Numbness Stiffness Weakness Other: _____

List all medications you are currently taking: □ None _____

List any known allergies: □ None _____
List any previous surgeries: □ None _____
Any diagnostic imaging for this injury? □ None MRI XRAYS CT SCAN Other: _____

Do you smoke? **Y___ N___** **How much/often?** _____
Do you consume alcohol? **Y___ N___** **How much/often?** _____
Do you exercise regularly? **Y___ N___** **How much/often?** _____