Confidential Medical History

Name:_______________________________________ Date of Birth: ___ / ___ / ___ SS#: _____-_____-________

Address: ____________________________________ City/State/Zip: ___________________________________

Phone: _________________________ Cell: ___________________________ Marital Status (Circle): M S D W

Employer: ____ Are presently working? Y N

Occupation: ______________________________________ Employer Phone: __________________________

Emergency Contact: _____________________________________ Phone: _____________________________

Primary Insurance: ______________________________ Secondary Insurance: ___________________________

Name of Card Holder: ____________________________ Date of Birth: ___ / ___ / ___ SS#: _____-_____-________

Is this a work or auto injury? Please Circle: Work Auto Date of Injury: ___ / ___ / ___

Email Address: ____

Have you had any physical, occupational, speech therapy or chiropractic treatment within the last year? Yes or No

Have you ever been treated here before? Yes or No

How did you hear about us? ____

Do you have or have you had any of the following conditions?

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	_____	_____	Osteoporosis	_____	_____
Shortness of Breath or Chest Pain	_____	_____	Pacemaker	_____	_____
Coronary Heart Disease	_____	_____	Stroke or TIA	_____	_____
Severe/Frequent Headaches	_____	_____	Diabetes	_____	_____
Low/High Blood Pressure	_____	_____	Pregnancy	_____	_____
Vision/Hearing Difficulties	_____	_____	Arthritis	_____	_____
Blood Clot or Emboli	_____	_____	Gout	_____	_____
Epilepsy or Seizures	_____	_____	Neurological Problems	_____	_____
Cancer or Chemotherapy/Radiation	_____	_____	AIDS / Hepatitis / TB	_____	_____
Emotional/Psychological Problems	_____	_____	Dizziness / Faintness	_____	_____
Do you have metal implants?	_____	_____	Bowel / Bladder Problems	_____	_____

Referring Physician: ____

List all medications you are currently taking: ☐ None

____

List any known allergies: ☐ None ____

List any previous surgeries: ☐ None ____

Have you had any diagnostic imaging for this injury? ☐ None Please Circle: MRI X-Rays CT Scan