MEDICAL HISTORY QUESTIONNAIRE

Due to your current diagnoses, have you had any of the following types of consultations? (Please check if yes):

_____Chiropractor
_____Massage Therapist
_____Acupuncture
_____Physical Therapy
_____Occupational Therapy
_____MRI/CT Scan
_____X-Ray
_____EMG
_____Nerve Conduction Study
_____Emergency Room Care

Have you had surgery in relation to your current diagnoses? _____Yes_____No

Have you ever been diagnosed with any of the following? (Please check if yes):

_____Diabetes
_____High Blood Pressure
_____Coronary Artery Disease
_____Heart Attack
_____Shortness of Breath
_____Dizziness or Fainting
_____Emphysema / COPD
_____Cancer
_____Osteoporosis
_____Osteopenia
_____HIV/AIDS
_____Radiation / Chemotherapy
_____Arthritis
_____Unexplained Weight Loss / Energy Loss
_____Epilepsy / Seizures
_____Kidney Disease
_____Anemia
_____Stroke / TIA
_____Hearing / Vision Difficulties
_____Bowel / Bladder Problems
_____Sleeping Problems
_____Emotional / Psych Problems
_____Are you Pregnant
_____ Do you use Tobacco
_____Frequent / Severe Headaches

Do you have a Pacemaker / Defibrillator (circle one) or any metal devices in your body?

Is this injury related to a Motor Vehicle or Worker's Comp. Accident? _____ Yes _____ No

Please list any surgeries or major injuries with date:

_____

_____

_____

MEDICATION LIST

Please list all medications you are currently taking with dosage and frequency, or provide the front desk Administrator with a list containing all information below.

Please include all supplements and vitamins

MEDICATION NAME	DOSAGE	FREQUENCY

Height:_____ Weight:_____

Blood Pressure:_____

Patient Signature:_____ **Date:**_____