**MEDICAL HISTORY**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF NEXT MD APPT: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

DESCRIBE THE HISTORY OF YOUR CURRENT ACCIDENT, INJURY, ILLNESS OR CONDITION:

ONSET DATE:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_DESCRIPTION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SPECIAL CONCERNS, QUESTIONS OR EXPECTATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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HAVE YOU FALLEN IN PAST YEAR? YES / NO IF YES, HOW MANY TIMES?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YES, DID YOU SUSTAIN AN INJURY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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HAVE YOU HAD ANY PHYSICAL THERAPY DURING THE CURRENT CALENDAR YEAR? YES/NO

IF YES, FOR WHAT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WHEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHERE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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LIST ALL RECENT DIAGNOSTIC STUDIES (CAT SCAN, MRI, X-RAY, ETC.), WHEN & WHERE: \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE METAL ANYWHERE IN YOUR BODY (OTHER THAN TEETH)? YES / NO

IF YES, PLEASE DESCRIBE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ALL SURGERIES AND DATES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PLEASE MARK YES (Y) OR NO (N) FOR EACH OF THE FOLLOWING:

ALLERGIES Y N DIZZY SPELLS Y N MRSA Y N

ANEMIA Y N EMPHYSEMA/BRONCHITIS Y N MULTIPLE SCLEROSIS Y N ANXIETY Y N FIBROMYALGIA Y N MUSCULAR DISEASE Y N

ARTHRITIS Y N FRACTURES Y N OSTEOPOROSIS Y N

ASTHMA Y N GALLBLADDER PROBLEMS Y N PARKINSON’S Y N

AUTOIMMUNE DISORDER Y N HEADACHES Y N RHEUMATOID ARTHRITIS Y N

CANCER Y N HEARING IMPAIRMENT Y N SEIZURES Y N

CARDIAC CONDITIONS Y N HEPATITIS Y N SMOKING Y N

CARDIAC PACEMAKER Y N HIGH CHOLESTEROL Y N SPEECH PROBLEMS Y N

CHEMICAL DEPENDENCY Y N HIGH/LOW BLOOD PRESSURE Y N STROKES Y N

CIRCULATION PROBLEMS Y N HIV / AIDS Y N THYROID DISEASE Y N

CURRENTLY PREGNANT Y N INCONTINENCE Y N TUBERCULOSIS Y N

DEPRESSION Y N KIDNEY PROBLEMS Y N VISION PROBLEMS Y N

DIABETES Y N METAL IMPLANTS Y N