



MEDICAL INFORMATION

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, we'll be happy to assist you. Thank You!

NAME _____ **AGE** _____ **DOB** _____
OCCUPATION _____ **LEISURE ACTIVITIES** _____

Please circle any of the following medical professionals you are currently seeing:

Medical Doctor Osteopath Psychiatrist/Psychologist Physical therapist Chiropractor Dentist

If you have been seen by any of the above during the last three months, please describe for what reason (illness, medical condition, physical examination, etc.)

Please circle any of the following conditions that you have EVER been diagnosed with and describe below:

High / Low Blood Pressure Heart problems Thyroid problems Diabetes Emphysema Asthma

Chemical dependency Alcoholism Multiple sclerosis Hepatitis Depression Stroke

Rheumatoid arthritis Tuberculosis Kidney disease Anemia Epilepsy AIDS

Other Arthritic conditions Cancer Other

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

<u>DATE</u>	<u>SURGERY / HOSPITALIZATION / REASON</u>
_____	_____
_____	_____
_____	_____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

<u>DATE</u>	<u>INJURY</u>
_____	_____
_____	_____

Please circle the conditions below that anyone in your immediate family (parents, brothers, sisters) have ever been treated for?

High / Low Blood Pressure Heart disease Kidney disease Diabetes Chemical dependency

Alcoholism Kidney disease Tuberculosis Epilepsy Mental illness

Arthritis Headaches Stroke Anemia Cancer

(Please turn over and complete questions on back)



Please circle the following **OVER-THE-COUNTER** medications you have taken in the last week.

Advil Motrin Ibuprofen Aspirin Tylenol Decongestants

Vitamins Mineral supplements Antacids Laxatives Antihistamines Other: _____

Please list any **PRESCRIPTION** medication you are currently taking (including pills, injections, and/or skin patches):

How much caffeinated coffee or other caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

How many days per week do you use marijuana? _____

How many days per week do you use drugs such as cocaine, crack, acid, etc.? _____

Please list any DRUG, FOOD, SEASONAL, or PRODUCT allergies:

Is there anything else you would like for us to know? (If yes please explain) _____

(Patient/Guardian Signature)

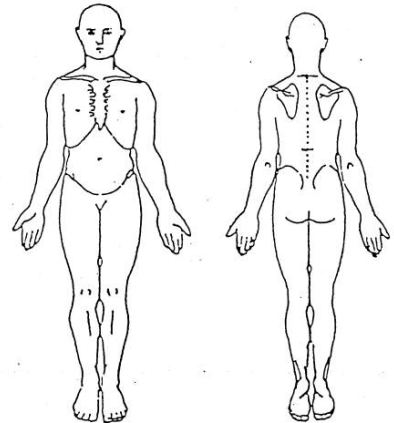
(Date)

Please circle either the correct answer to the question below:

Have you currently experienced:

On the illustration below please identify areas of pain with an "X" and areas of numbness with an "O".

- 1. **YES NO** Weight loss / gain
- 2. **YES NO** Nausea / vomiting
- 3. **YES NO** Fatigue
- 4. **YES NO** Weakness
- 5. **YES NO** Fever / Chills / Sweats
- 6. **YES NO** Numbness or tingling



*

Date

(Patient / Guardian Signature)

For office use only

Reviewed by: _____

Date: _____

Notes: