Confidential Medical History

Patient Name	**Age** **Birth Date**
Address **City**	**Home Phone**
Social Security Number	**Cell Phone**
Insurance Company	**Work Phone**
Date of Injury / Onset	**Currently working?**
Referring Physician	**Next doctor's appointment**
Employer	**Occupation**

Single **Married** **Spouse's Name / Next of Kin**

HAVE YOU HAD PHYSICAL THERAPY THIS YEAR? **WHEN?** **Have you had a chiropractic treatment?**

- Medical Conditions –

- Check conditions you currently have or have had in the past.

GENERAL	CARDIOPULMONARY	ORTHOPEDIC	NEUROLOGICAL/PSYCHOLOGICAL
☐ Hepatitis	☐ Asthma	☐ Physical handicap	☐ Mental handicap
☐ Diabetes	☐ Black lung	☐ Gout	☐ Epilepsy
☐ Cancer	☐ Pacemaker	☐ Cervical (Neck)	☐ Seizures
☐ Infection	☐ Heart attack	☐ Lumbar (Low Back)	☐ Dizziness
☐ Migraines	☐ High blood pressure	☐ Shoulder	☐ Vertigo
☐ Kidney problems	☐ Heart condition	☐ Elbow	☐ Stroke
☐ Rheumatic fever	☐ Breathing problems	☐ Wrist/Hand	☐ Anxiety
☐ Hearing problems	☐ Mitral Valve Prolapse	☐ Hip	☐ Clinical Depression
☐ Sight problems	☐ Tuberculosis	☐ Knee	☐ Bipolar Disorders
☐ Speech problems	☐ Emphysema	☐ Ankle	☐ Schizophrenia
☐ Alcohol/Drug Dependency	Do you smoke? ☐Yes ☐No	☐ Foot	☐ Other:

HEIGHT ____________________ **WEIGHT** _________________

- Medications –

List all medications you are currently taking. If you cannot remember the names of your medication just list the conditions for which you take medications.

- Prior Surgery -

Please list all previous surgeries you have had.

- Allergies -

List all allergies you have.

To the best of my knowledge the above information is complete and correct.

X____ ____________________

Signature of Patient, Guardian, or Patient Representative ***Date***

I have reviewed this Medical History form. ____________________________________ ____________