PATIENT MEDICAL HISTORY

Name____ Age________________

Occupation____

Type of Work Involved____

Do you have a history of any of the following?:

High Blood Pressure	Yes	No	Cancer	Yes	No
Heart Condition	Yes	No	Seizures	Yes	No
Stroke	Yes	No	Back/Neck Injury	Yes	No
Diabetes	Yes	No	Other Joint Injury	________________	
Pacemaker	Yes	No	Other___________________________		

Have you had Home Health Care for this injury / illness? Yes No

When is your follow-up appointment with your doctor? ___________________________

Have you had any surgeries in the past 5 years? Yes No
Please list:____

Have you had previous physical therapy? Yes No
Please list:____

Are you taking any medications? Yes No
Please list:____
____
____

Are you currently under the care of a chiropractor? Yes No
ATTN: *All Blue Cross / Blue Shield members must inform the front desk if they are currently under a chiropractor's care, or if they have any upcoming chiropractic appointments.**

What types of activities would you like to return to?____
____

Who should we call in case of emergency?______________________ Phone: _______________

Relationship to patient (please specify): Spouse Parent / Guardian
Friend Child Other __________________________

I certify that the above information is true and complete to the best of my knowledge.

____ __________________________
Signature of Patient (parent / guardian if patient is a minor) ***Date***