Patient Medical History

Patient Name: ______________________________ **Age:** ___________

Occupation: ________________________________ **Work Status:** ___________

Please check the following conditions as they apply to you:

Condition	Yes	No	Explanation
Allergies			
Heart Disease			
High Blood Pressure			
Pacemaker			
DVT / Pulmonary Embolism			
Diabetes			
TB			
Hepatitis			
Psoriatic Arthritis			
Rheumatoid Arthritis			
Lupus			
Fibromyalgia			
Multiple Sclerosis			
Muscular Dystrophy			
Ankylosing Spondylitis			
Cancer			
Traumatic Head/Brain Injury			
Stroke			
Severe Dizziness			
Seizures			
Kidney Disorders			
Blood Disorders			
Thyroid Disorder			
Oseteoporosis			
Gastrointestinal			
Difficulty Swallowing			
Weight Loss or Gain			
Eating Disorder			
Chronic Fatigue Syndrome			
Sleep Dysfunction: Insomnia			

Please list your current daily medications:

Name of Medication	Dosage	Frequency

Are you in pain today: _________ **If you answered yes, how would you rate your pain** (1 = minimal pain / 10 = worst pain you've ever experienced): ___________

Have you had any imaging for this condition? Circle all that apply: X-Ray MRI CT Scans
Date of Imaging: ____

Primary Care Physician: __________________________________

Date of last complete medical exam: __________________

Have you had any past or present surgical procedures: _________________ **If you answered yes, please list:** ____
____

How many hours of sleep do you get per night: ______________________

Do you wake frequently at night: _______________ **If you answered yes, how often:**
____

Do you have a bladder condition: _____________

Do you experience frequent urination: ________________

Leakage with coughing, laughing, or sneezing: ________________

Do you feel you are under a lot of stress: __________________

Do you exercise on a regular basis: ______________ **If you answered yes, please list the activities, frequency, and duration:** ____

Are you currently pregnant: ____________ **Or have been in the last year:** ________________

Do you smoke: __________ **How many packs per day:** ___________________

Do you drink alcohol: ________ **How often:** __________________________

Have you ever been treated for depression or psychological problems (optional): __________
If yes, please explain: ____