Client Name:_________________________________DOB:_________________

Patient Medical History

The receptionist will be happy to answer questions or assist you with this questionnaire.

Please *circle Y or N* for each of the following questions. Have you ever experienced or been diagnosed with:

Y	N	Headaches, dizziness, weakness, fainting	Y	N	***Unexpected*** weight change Gain: _______ lbs. Loss: _________ lbs.
Y	N	Problems with coordination or balance	Y	N	Head injury causing severe dizziness, loss of memory, vomiting, unconsciousness
Y	N	Epilepsy	Y	N	Heart trouble or cardiovascular difficulty
Y	N	Osteoporosis	Y	N	Stroke
Y	N	Arthritis or rheumatism	Y	N	Diabetes
Y	N	High blood pressure	Y	N	Surgery of any type within the last 18 months
Y	**N**	**Do you have a pacemaker?**	Y	N	Women: are you pregnant, or think you may be pregnant?
Y	N	Allergies Please list:	Y	N	Any other new, unexpected or unusual symptoms:

Y N Cancer: Type of cancer and location:

Date of diagnosis: Type of Treatment(s):

Current status: ☐ in remission ☐ in treatment ☐ cancer-free for _________ years

Y N Have you ever been required to take steroids (e.g., Prednisone) for a long period of time?

Your Occupation(s):

____

____

Hobbies and sports:

____

____

Drugs, Food supplements and miscellaneous agents:

Y N Are you taking any prescription medications? Please list:

Y N Are you taking any non-prescription drugs? (sleeping pills, cold/allergy medication, herbs and supplements, etc.) Please list:

Y N Do you smoke? Packs/day:

Y N Do you drink alcoholic beverages? Approximately how much per week (average)?

On the diagram below, please circle the painful area(s):

Left Right

BACK

Right Left

FRONT

Date of Injury:

Date of Accident/Incident (if different):

Injury Type:

Please indicate other health practitioners that you see.

- ❑ Acupuncturist
- ❑ Chiropractor
- ❑ Massage Therapist
- ❑ Naturopath/Herbalist
- ❑ Osteopath
- ❑ Podiatrist or Chiropodist
- ❑ Other:

Chart #: [ ]

Therapist Initial:

Pain Rating using the "Visual Analog Scale"
Please complete this form when you arrive for your appointment

Zero (0) at the left side of the page, indicates no pain at all. Ten (10) at the right side of the page indicates pain that is unbearable. Please make a single vertical mark on each line at the position that best indicates the amount of pain you feel. For example:

0 ——|—— 10

at its WORST in the past 24 hours:

0 (no pain) ______________________ 10 (unbearable pain)

at its LEAST in the past 24 hours:

0 (no pain) ______________________ 10 (unbearable pain)

AVERAGE:

0 (no pain) ______________________ 10 (unbearable pain)

RIGHT NOW:

0 (no pain) ______________________ 10 (unbearable pain)

Are you currently taking medication to help manage your pain? ❑Y ❑N

If Yes, do you know what type of medication and what dosage are you using?
❑"Over the counter" medication:
❑Aspirin ❑Tylenol Strength (i.e. mg/tablet) ________
❑Ibuprofen ❑Other:______________________
❑Anacin # tablets per day: _______

❑ Prescription medication: _________________________

Strength (i.e. mg/tablet) ______________ # tablets per day: _______

Date: ________________________

☞ Patient ***OR*** Parent/Guardian Signature: ______________________________________ ☜

Scored by: ____________________

Chart #: [ ] Therapist Initial: