

Name _____ Age _____ DOB _____ Today's Date _____

Occupation: _____

Source of Referral _____

Present Medical Problem, How and When It Began: _____

Have You Had (Please Circle) X-rays, MRI, CT Scan Related To This Problem?
 When? _____

Have You Been Seen By Other Physicians Or Therapists For This Problem? ___ No ___ Yes

Names _____

List Current Medications and Dosage _____

Have You Ever Received Cortisone Or Steroids In the Past? _____ No _____ Yes

What and When? _____

Are You Allergic To Any Medications? _____

What Alternative Medical Therapies Have Been Tried?

List Other Significant Medical Conditions? _____

REVIEW OF SYSTEMS

	YES	NO		YES	NO
Bleeding Tendencies			Diabetes		
Hypertension			Kidney Disease		
Heart Murmur			Cancer		
Heart Attack			Visual Difficulties		
Angina			Chronic Headaches		
Asthma			Arthritis		
Breathing Difficulties			Gout		
Shortness of Breath			Epilepsy Seizure		
Thyroid			Fainting Spells		
Heartburn			Extreme Weight Loss/Gain (lbs) _____		
Hiatal Hernia			History of Depression or Psychotic Problem		
Stomach Ulcers					
Limited Motion					
Weakness					
Numbness					

OVER PLEASE...

