MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____
Referring Physician: _____

Are you currently taking any prescription or non-prescription medication? ☐ Yes ☐ No
List medications: _____
_____

Are you allergic to any medications? ☐ Yes ☐ No Latex allergy? ☐ Yes ☐ No
List medications: _____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

	Yes	No		Yes	No
Chiropractor	☐	☐	CT Scan	☐	☐
EMG/NCV	☐	☐	General Practitioner	☐	☐
Massage Therapy	☐	☐	MRI	☐	☐
Myelogram	☐	☐	Neurologist	☐	☐
Occupational Therapy	☐	☐	Orthopedist	☐	☐
Physical Therapy	☐	☐	Podiatrist	☐	☐
Emergency Room	☐	☐	X-Ray	☐	☐

Other: _____

Have you ever had ANY of the following?

	Yes	No		Yes	No
Asthma, bronchitis, or emphysema, Shortness of breath/chest pain	___	___	Severe/frequent headaches	___	___
Coronary heart disease or angina……	___	___	Vision or hearing difficulties...	___	___
Do you have a pacemaker ……	___	___	Numbness or Tingling……	___	___
High blood pressure……	___	___	Dizziness of Fainting……	___	___
Heart Attack or Heart Surgery……	___	___	Bowel or Bladder Problems	___	___
Stroke/TIA……	___	___	Weakness……..	___	___
Blood Clot/Emboli……..	___	___	Weight loss/energy loss……	___	___
Epilepsy/seizures……	___	___	Hernia……..	___	___
Thyroid Disease or goiter……	___	___	Varicose veins……	___	___
Anemia……..	___	___	Any pins or metal implants...	___	___
Infectious Diseases……	___	___	Joint replacement surgery…	___	___
Diabetes……	___	___	Neck injury/surgery……	___	___
Cancer or chemotherapy/radiation……	___	___	Shoulder injury/surgery……	___	___
Arthritis……..	___	___	Elbow/hand injury/surgery…	___	___
Osteoporosis……	___	___	Back injury/surgery……	___	___
Gout……..	___	___	Knee injury/surgery……..	___	___
Sleeping problems/difficulties……	___	___	Leg/ankle/foot injury/surgery	___	___
Emotional/psychological problems……	___	___	Are you pregnant? ……..	___	___
			Do you use tobacco?……	___	___

_____ _____
Patient/Guardian Signature Date