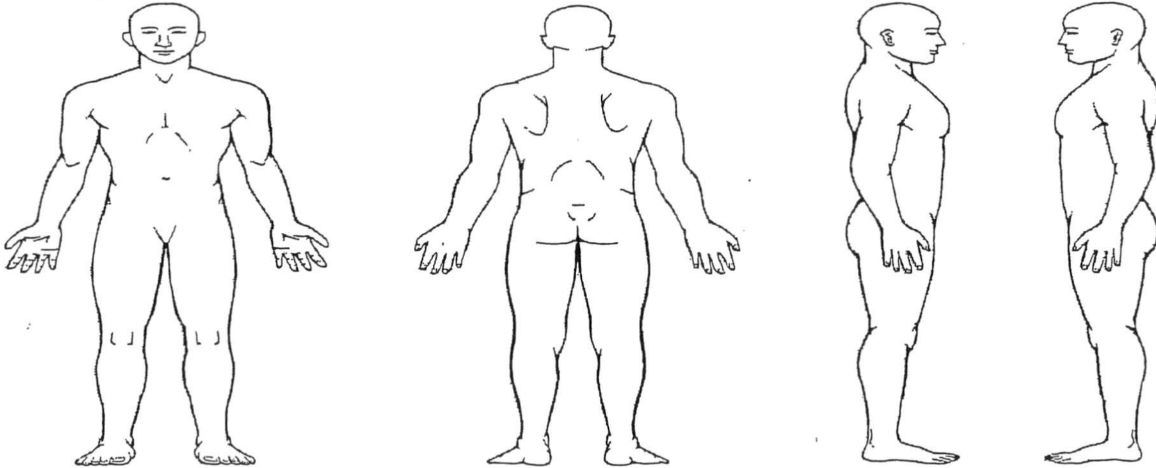
MEDICAL HISTORY FORM

Name ____ Date of Birth______

Age_______ Weight________ Height__________

Please circle the area (s) you are having pain:



Please list:

Diagnostic Tests (MRI/XRAY/CT scan): ________________________________

Surgeries/Hospitalizations: ________________________________

Medications: ________________________________

Please check the following that apply:

Unexplained weight loss	☐	Respiratory problems	☐	COPD	☐
Night pain	☐	Dizziness	☐	Ehlers-Danlos	☐
Fever/Chills	☐	Headaches	☐	Lymphedema	☐
Fractures	☐	Cardiac problems	☐	Multiple sclerosis	☐
Arthritis	☐	Metal implants	☐	Parkinson's	☐
Numbness/Tingling	☐	Thyroid problems	☐	Rheumatoid arthritis	☐
Depression	☐	Anxiety	☐	Pacemaker	☐
Diabetes	☐	Substance abuse	☐	Anemia	☐
High blood pressure	☐	Low blood pressure	☐	Cancer	☐
Allergies	☐	Steroid use (corticosteroids)	☐	Urinary incontinence	☐

Any other medical condition: ________________________________

Patient Signature: ________________________ Date:______________

Reviewed By: ________________________ Date:______________