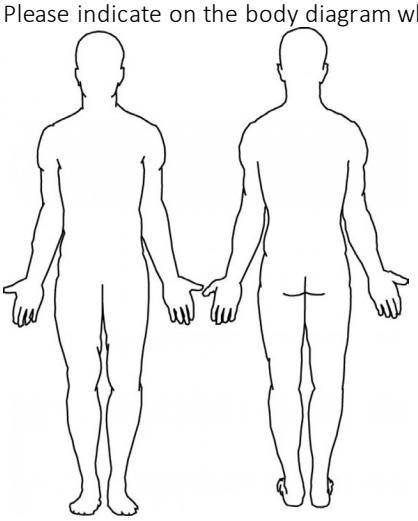
PATIENT MEDICAL HISTORY

1. Which of the following *best describes* your condition? (If your condition is post-surgical, please indicate as per original condition)
   ☐ lifting ☐ degenerative process ☐ a fall ☐ an incident at work ☐ overuse (cumulative trauma) ☐ during recreation/sports
   ☐ MVA (car accident) State accident occurred ____ Driver/Passenger if MVA (circle one) ☐ unknown ☐ other_____

   *Onset Date of Symptoms _____/_____/_____ *Surgery Date if applicable_____/_____/_____

2. Nature of primary complaint (check all that apply):
   ☐ pain ☐ numbness/tingling ☐ sharp ☐ aching ☐ constant ☐ dull ☐ burning ☐ weakness ☐ throbbing ☐ intermittent

   Please indicate on the body diagram where your symptoms are located:



3. Please check any other health care providers you are currently seeing for this condition: ☐ MD ☐ Dentist ☐ Podiatrist ☐ Chiropractor ☐ Physical Therapist

4. Please check if you have had any of the following: ☐ EMG ☐ XRAY ☐ MRI ☐ CT SCAN

5. If retired, permanently disabled, or unemployed, skip to section 6.

Physical activities at work: ☐ sitting ☐ standing ☐ computer use ☐ phone use ☐ repetitive lifting ☐ driving ☐ heavy lifting ☐ walking ☐ bending ☐ crawling ☐ heavy equipment operation

If not performing your normal activities at work, do you plan to return to your previous activity level? ☐ Yes ☐ No

If you were injured on the job, please describe how the incident occurred.

_____

_____.

6. Please list ALL prescriptions, over the counter medications, herbal supplements, and vitamins you are currently taking with dosage, frequency, and route of administration (oral, injection, inhalation, etc) or provide a list of your own for the receptionist to copy:

Name	Dosage	Frequency	Route of Administration

7. Please list any allergies you have _____
8. Please list any surgeries you have had _____
   _____
9. Please list your therapy goals: _____

Patient/Guardian Signature: _____ Date: _____