

REASON FOR THIS EXAMINATION: (Please check & indicate right or left side)

Spine _____ Wrist or Hand Problems _____ Leg Problems _____
 Neckache _____ Hip Problems _____ Foot or Ankle _____
 Shoulder or Elbow _____ Knee Problems _____ Other _____

Have you been under another therapist's care for this condition? Yes _____ No _____

If Yes, Name of Therapist: _____

Have you had surgery for this condition? Yes _____ No _____

If Yes, What kind? _____ When? _____

Are your present problems related to an accident/injury? Yes _____ No _____

If yes, please complete the following:

Date: _____ Place: _____

Auto _____ Work Related _____ Home _____ Other (specify) _____

Is legal action involved? Yes _____ No _____ Name of Attorney: _____

MEDICAL HISTORY

Are you RIGHT or LEFT Handed? (Please check) () Right () Left

Do you consider yourself in good health? Yes _____ No _____

Name of family or private physician: _____

WHO referred you to this office? _____ Date of last office visit: _____

PAST MEDICAL HISTORY (Illnesses and / or Injuries) (Please circle)

1. Fractures or joint injuries _____ 6. Nervous or Mental Disease _____

2. Backache or Neckache _____ 7. Circulation Disorder _____

3. Arthritis or Gout _____ 8. Lung Disease, Emphysema, _____

4. Heart Disease _____ Asthma, Pneumonia _____

5. Diabetes (sugar) _____ 9. Stomach, Bowel or Liver Disease _____

PAST OPERATION (and Approximate Date)

1. Bone or joint _____ 5. Lung _____

2. Stomach or Bowel _____ 6. Heart or Blood Vessel _____

3. Gall Bladder _____ 7. Kidney, Bladder or Prostate _____

4. Hysterectomy _____

FAMILY HISTORY: (Mother, Father, Sister, Brother) (Please Circle)

1. Arthritis (crippling) _____ 5. Stroke _____

2. Gout _____ 4. Heart Disease _____

6. Cancer _____

MEDICATIONS

Are you ALLERGIC to any medication? Yes _____ No _____

If Yes, please list _____

What medications are you currently taking? _____