PAST MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____
Reason for Therapy: _____
_____
Date of Injury: _____
Have you ever received therapy for the above mentioned condition? Yes No
If so, when: _____ Treatment Received: _____
_____
Was the treatment received successful? Yes No

Could you be or are you pregnant? Yes No

Do you now or have you ever had any of the following:

Hepatitis	Yes	No	Diabetes	Yes	No
Thyroid Problems	Yes	No	Hernia	Yes	No
Arthritis	Yes	No	Anemia	Yes	No
Osteoporosis	Yes	No	Hypersensitivity to Hot/Cold	Yes	No
High Blood Pressure	Yes	No	Swelling in Ankles	Yes	No
Heart Disease	Yes	No	Deep Vein Thrombosis (DVT)	Yes	No
Heart Attack	Yes	No	Seizures/Epilepsy	Yes	No
Pacemaker	Yes	No	Metal/Surgical Implants	Yes	No
Vascular Disease	Yes	No	Cancer/Tumor	Yes	No
Stroke	Yes	No	Recent Weight Loss or Gain	Yes	No
Asthma	Yes	No	Current Infections	Yes	No
Shortness of Breath	Yes	No	Kidney/Bladder Problems	Yes	No
Chronic Cough	Yes	No	Substance Abuse	Yes	No
Fainting Spells	Yes	No	Head Injury/Concussion	Yes	No
Previous Fractures	Yes	No	Tuberculosis	Yes	No
Hearing Loss	Yes	No	Depression	Yes	No
Anxiety	Yes	No	Previous Surgeries	Yes	No
Other	Yes	No			

If you answered "yes" to any of the above, please explain and give the approximate date(s):
_____
_____
_____
Do you have any allergies? Yes No List allergies: _____
Are you presently taking any medications? Yes No
If yes, please list medications: _____
_____

The above information is correct to the best of my knowledge.
Signature of Patient/Parent/Guardian

_____ Date: _____