

Legal Name _____ Date _____

Please describe your injury or pain:

Location on body _____

When did this first begin _____ Is it now: better, worse, or the same?

Describe how you were injured/pain began _____

How have you been treating this injury? _____

Medical History

- | | | | | | |
|----------------------|--|----------------------|--|----------------------|--|
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinsons | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema/Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gallbladder Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Speech Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Strokes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Incontinence | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulation Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vision Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Currently Pregnant | <input type="checkbox"/> Yes <input type="checkbox"/> No | Metal Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Please describe any other conditions or precautions:

Fall History

Have you had an injury as a result of a fall in the past year? Yes No

Have you had two or more falls in the last year? Yes No

Surgical History

Body Region:

Surgery Type:

Date of surgery (month/year):

Current Medications

Drug:

Dosage:

Reason Taking: