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	□ Yes □ No	Depression	□ Yes □ No	Multiple Sclerosis	□ Yes □ No
Anemia	□ Yes □ No	Diabetes	□ Yes □ No	Osteoporosis	□ Yes □ No
Anxiety	□ Yes □ No	Dizzy Spells	□ Yes □ No	Parkinsons	□ Yes □ No
Arthritis	□ Yes □ No	Emphysema/Bronchitis	□ Yes □ No	Rheumatoid Arthritis	□ Yes □ No
Asthma	□ Yes □ No	Fractures	□ Yes □ No	Seizures	□ Yes □ No
Cancer	□ Yes □ No	Gallbladder Problems	□ Yes □ No	Speech Problems	□ Yes □ No
Cardiac Conditions	□ Yes □ No	Hepatitis	□ Yes □ No	Strokes	□ Yes □ No
Cardiac Pacemaker	□ Yes □ No	High Blood Pressure	□ Yes □ No	Thyroid Disease	□ Yes □ No
Chemical Dependency	□ Yes □ No	Incontinence	□ Yes □ No	Tuberculosis	□ Yes □ No
Circulation Problems	□ Yes □ No	Kidney Problems	□ Yes □ No	Vision Problems	□ Yes □ No
Currently Pregnant	□ Yes □ No	Metal Implants	□ Yes □ 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: