



HEALTH HISTORY

Please fill out this Health History form as complete as possible. It will assist your therapist in developing a plan of care for you. If you have any questions please feel free to ask for assistance.

NAME: _____ DATE OF BIRTH: _____

OCCUPATION: _____

SPORTS/ACTIVITES: _____

WAS THIS INJURY THE RESULT OF AN ACCIDENT? YES NO

IF YES, DATE OF INJURY: _____ SUDDEN ONSET GRADUAL

HAS THIS INJURY PREVENTED YOU FROM WORKING? YES NO

IF YES, HOW LONG HAVE YOU BEEN OFF WORK? _____

PRESENT WORK STATUS: FULL-TIME PART-TIME OTHER

IS THERE AN ATTORNEY INVOLVED WITH THIS CASE? YES NO

IF YES, ATTORNEY NAME: _____ PHONE () _____

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION?

- | | |
|---|---|
| <input type="checkbox"/> NO OTHER TREATMENT | <input type="checkbox"/> PHYSICAL/OCUPATIONAL THERAPY |
| <input type="checkbox"/> CHIROPRACTIC | <input type="checkbox"/> OTHER |

LIST ALL PRESCRIPTION MEDICATIONS YOU ARE TAKING (INCLUDING INJECTIONS AND SKIN PATCHES):

LIST ALL OVER THE COUNTER MEDICATIONS YOU ARE TAKING (INCLUDING VITAMINS AND SUPPLEMENTS):

ALLERGIES TO MEDICINE? YES NO IF YES, LIST: _____

DO YOU, OR HAVE YOU EVER HAD ONE OF THE FOLLOWING:

- | | | |
|--|---|--|
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEART TROUBLE |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEART PACE MAKER | <input type="checkbox"/> TUMOR |
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> METAL IMPLANTS | <input type="checkbox"/> BLOODCLOTS |

OTHER MEDICAL PROBLEMS NOT LISTABOVE: _____

ARE YOU PREGNANT? YES NO IF YES, DUE DATE: _____