



## MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis/Surgery: \_\_\_\_\_

When and how did your problem begin? \_\_\_\_\_

\_\_\_\_\_

Current Symptoms: \_\_\_\_\_

\_\_\_\_\_

Have you had this problem before? \_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_

\_\_\_\_\_

What makes your symptoms better? \_\_\_\_\_

\_\_\_\_\_

Have you had any diagnostic tests recently? (ie x-rays, MRI, CT scan, etc...) \_\_\_\_\_

\_\_\_\_\_

What are your expectations from therapy? \_\_\_\_\_

\_\_\_\_\_

Please List all prescription and non-prescription medications you are taking: \_\_\_\_\_

\_\_\_\_\_

Are you allergic to any medications? (please list) \_\_\_\_\_

Medical History: \_\_\_\_\_

\_\_\_\_\_

Surgical History: \_\_\_\_\_

\_\_\_\_\_

Do you normally work outside your home? \_\_\_\_\_ If yes, are you currently working? \_\_\_\_\_

Are you able to complete all work duties? \_\_\_\_\_ If no, please explain: \_\_\_\_\_

\_\_\_\_\_

Any limitations around your home? (ie care of dependents, laundry, cooking, driving, cleaning, etc...) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_