



# Medical History

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Reason for therapy: \_\_\_\_\_

Date of Injury/Onset: \_\_\_\_\_

Have you previously received therapy for this condition?  yes  no If so, when? \_\_\_\_\_

Previous treatment received? \_\_\_\_\_

For our female patients: Could you be, or are you pregnant?  yes  No

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

Arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis	<input type="checkbox"/> yes <input type="checkbox"/> no
Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	Hernia	<input type="checkbox"/> yes <input type="checkbox"/> no
Anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	High Blood Pressure	<input type="checkbox"/> yes <input type="checkbox"/> no
Anxiety	<input type="checkbox"/> yes <input type="checkbox"/> no	Infections	<input type="checkbox"/> yes <input type="checkbox"/> no
Bladder Problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney Problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Chronic Cough	<input type="checkbox"/> yes <input type="checkbox"/> no	Metal in body	<input type="checkbox"/> yes <input type="checkbox"/> no
Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	Osteoporosis	<input type="checkbox"/> yes <input type="checkbox"/> no
Clotting / DVT	<input type="checkbox"/> yes <input type="checkbox"/> no	Osteopenia	<input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	PaceMaker	<input type="checkbox"/> yes <input type="checkbox"/> no
Depression	<input type="checkbox"/> yes <input type="checkbox"/> no	Respiratory Problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Dizziness	<input type="checkbox"/> yes <input type="checkbox"/> no	Seizures	<input type="checkbox"/> yes <input type="checkbox"/> no
Epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no	Sensitivity to cold/hot	<input type="checkbox"/> yes <input type="checkbox"/> no
Fainting Spells	<input type="checkbox"/> yes <input type="checkbox"/> no	Shortness of Breath	<input type="checkbox"/> yes <input type="checkbox"/> no
Fractures	<input type="checkbox"/> yes <input type="checkbox"/> no	Stroke	<input type="checkbox"/> yes <input type="checkbox"/> no
Gout	<input type="checkbox"/> yes <input type="checkbox"/> no	Surgeries	<input type="checkbox"/> yes <input type="checkbox"/> no
Headaches	<input type="checkbox"/> yes <input type="checkbox"/> no	Swelling	<input type="checkbox"/> yes <input type="checkbox"/> no
Head Injury	<input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid Problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Hearing Loss	<input type="checkbox"/> yes <input type="checkbox"/> no	Tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart Attack	<input type="checkbox"/> yes <input type="checkbox"/> no	Vascular Disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Weight Loss /Gain	<input type="checkbox"/> yes <input type="checkbox"/> no

If you answered "yes" on any of the above, please explain and give approx dates and treatment:

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Allergies?  no  yes; List allergies: \_\_\_\_\_

Are you presently taking any Medications?  no  yes, list medications and specify condition:

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**This information is correct and complete to the best of my knowledge.**

\_\_\_\_\_  
**Signature:** Patient / Parent / Guardian

**Date:** \_\_\_\_\_