Balance & Mobility Therapy

MEDICAL HISTORY FORM

Please fill this form out, print, and turn in at your first appointment.

Name:____ Age:______________________

Area of Symptoms:____

Date Symptoms Started:____

Please take a moment to complete the questions below. Depending on your answers, we may modify treatment procedures for their effectiveness and you safety.

Any known results of recent X-rays or tests:____

Chronic Conditions: Yes No if yes, please list: ___________________________

Medications: Yes No if yes, please list:__________________________________

Allergies: Yes No if yes, please list:__________________________________

Latex Sensitive: Yes No

List surgeries and dates:____

Do you or have you had any of the following:

Cancer	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Metal Implants	Yes	No
Epilepsy/Seizures	Yes	No	Respiratory Problems	Yes	No
Heart Disease	Yes	No	Hepatitis	Yes	No
Tuberculosis	Yes	No	Are you pregnant?	Yes	No

1. How would you rate your ability to perform your routine daily activities?

   (no problems) 0 1 2 3 4 5 6 7 8 9 10 (unable to perform)

2. How would you rate your ability to perform the activities associated with your job?

   (no problems) 0 1 2 3 4 5 6 7 8 9 10 (unable to perform)

3. How many days since your current injury? 0-30 days 31-90 days 91+ days

How did you select our service?

Doctor recommendation	Previous patient	Ad in phone book
Insurance provider directory	Family/Friend recommended	Internet Search
Radio	Newspaper	Other________________

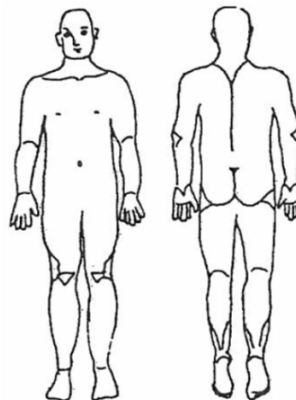
Please draw your pain on the body to the right using the following symbols: Please do so after you print this form out.

/// Stabbing Pain

xxx Burning Pain

ooo Pins and Needles

= = = Numbness



____ ____________________________

Patient Name Date