



MEDICAL HISTORY QUESTIONNAIRE

1.) What is your reason for seeking treatment (if more than one reason, please list in order of importance)?

2.) Date of injury/surgery/beginning of symptoms? _____

3.) Do you have any problems with:

a. Allergies? NO YES: _____

b. Heart Condition? NO YES: _____

c. Seizure Disorder? NO YES: _____

d. Diabetes? NO YES Hypoglycemia? NO YES

4.) Are you pregnant? NO YES What Trimester? _____

5.) Who is your primary care physician? (first and last name) _____

6.) Have you sought treatment elsewhere for this problem? (i.e. Chiropractic/P.T./Massage/Other)

7.) What are your goals? _____

8.) Is this injury related to a(n): **N/A** **Motor Vehicle Accident (MVA)** **Industrial (Work)**

How did injury occur? _____

Date of injury: _____ Was another party responsible? YES NO

9.) Please list any current medications:

10.) Please list any pertinent family history of medical problems (i.e. mother has osteoporosis; grandfather had knee replacement due to arthritis):

Patient Name (Print) Patient/Guardian Signature Date