

Previous Medical History Form



Name: _____ Birthdate: _____ MHC1213
Phone #: _____ Email: _____ Age: _____
Height: _____ Weight: _____ Sex: M F Hand Dominance: L/R/ Ambidextrous
Current Diagnosis: _____
Referring Physician: _____ Primary Language: _____

How do you prefer to learn: (Please circle one) Visual or Auditory

Medical History: (Please check all that apply)

- Heart Disease, Diabetes, High Blood Pressure, Pacemaker/Aneurysm clips, Dizziness/Fainting, Epilepsy/Seizures, HIV/AIDS, Arthritis, Hearing Impaired, Visual Impaired, Stroke, Asthma/Shortness of Breath, Latex Allergy, Osteoporosis, Hepatitis/Liver problems, Hives/Skin rash, Gout, Anemia/Blood disorders, Ulcers, Polio, Joint Replacements, Cancer- Please explain: _____, Tuberculosis

Do you consume alcohol: [] Yes [] No If so, how much (how many drinks per week) _____
Do you smoke: [] Yes [] No If so, how many packs per day and are you willing to cut down to increase healing rate for your condition? _____
Do you consume caffeine (coffee, tea, soft drinks)? If so, how many per day? _____
Are you allergic to anything? _____
If you are female, is there any possibility that you are pregnant? [] Yes [] No
How did your injury occur and when (or how long have you been having symptoms) and do you know why? _____

Have you had any prior/previous diagnostic test for this condition you are being seen for today? (Please circle if applicable): X-ray, MRI, CT scan, Arthrogram, Nerve conduction tests, EMG,



Have you had any prior/previous treatments for this condition you are being treated for today? Yes No

Injections: (If so, how many and where) _____

Chiropractic: (If so, when and how many treatments) _____

Therapy: (If so, when and how many treatments) _____

What kind of outcome did you have with these treatments: Significant improvements,
 Marginal improvements, Short term Symptomatic relief, No improvement, or Worsening

Is your pain? (Please circle one) Constant, Intermittent, Brief, Momentary, Periodic, Transient

Please rate your pain using a 0-10 scale: (0= No pain, 10= worse pain you can imagine)

Worse pain since onset: _____ Worse pain in the past 4 weeks: _____

Least amount of pain since onset: _____ Today's pain: _____

Does the pain wake you up at night: Yes No

What position helps you sleep? _____

What makes your pain better? _____

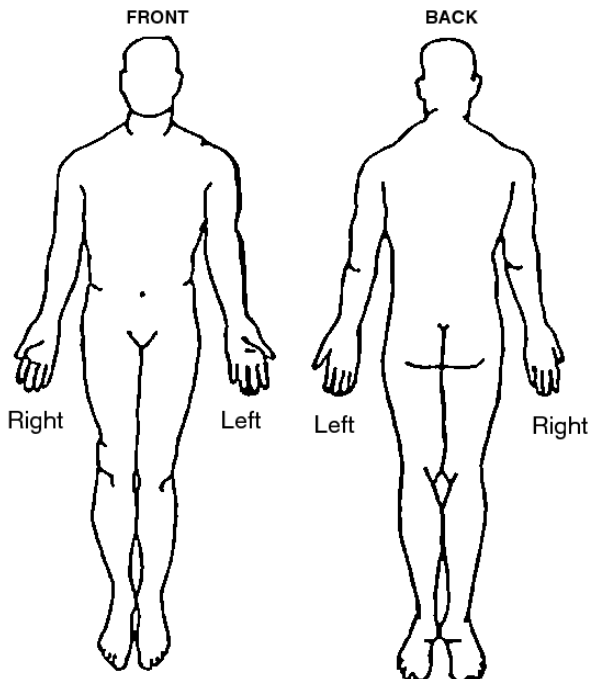
What makes you pain worse? _____

Please use the key to indicate the location & nature of your pain on the diagram below

NCN PAIN DRAWING GRID ASSESSMENT

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
////	B B B	X X X X	===	Z Z Z	O O O O
///	B B B	X X	===	Z Z Z	O O O O

Percentage of pain in back _____ Percentage of pain in legs _____



NO PAIN 1 2 3 4 5 6 7 8 9 10 INTOLERABLE PAIN
(CIRCLE YOUR PAIN ESTIMATE)





MHC1212

SIGNIFICANT MEDICAL DIAGNOSIS & CONDITIONS		
DATE/TIME	LIST	COMMENTS

SIGNIFICANT OPERATIVE & INVASIVE PROCEDURES			
DATE/TIME	LIST	DATE OF PROCEDURE	COMMENTS

MEDICATIONS (Prescription, Over-the-Counter, Herbal, Vitamins)					
DATE/TIME	DRUG NAME	ROUTE	DOSAGE	FREQUENCY	INDICATION

ADVERSE OR ALLERGIC DRUG REACTIONS		
DATE/TIME	LIST	COMMENTS

* INITIATED FOR THE PATIENT BY THE THIRD VISIT AND MAINTAINED THEREAFTER.
 * EXERCISE FLOWSHEETS WILL BE UTILIZED TO DOCUMENT WHETHER OR NOT CHANGES HAVE OCCURRED.

Therapist: _____ Date/Time: _____



