MEDICAL HISTORY SURVEY

Name: _____

DOB: _____

VISIT HISTORY

Date	Reason For Today's Visit	How Long?

PREVIOUS HOSPITALIZATIONS, SERIOUS ILLNESSES, and SERIOUS INJURIES:

Reason: _____
Date: _____
Reason: _____
Date: _____
Reason: _____
Date: _____
Reason: _____
Date: _____

HEALTH HABITS – Indicate how much:

☐ Caffeine: _____
☐ Tobacco: _____
☐ Alcohol: _____
☐ Illegal Drugs:

NUTRITION:

Would you like to have our registered dietitian contact you about your nutritional needs and goals? ☐YES ☐NO

PREGNANCY:

If you are female, is it possible that you may be pregnant at this time? ☐YES ☐NO

SAFETY:

Are you at risk for falling? ☐YES ☐NO
Do you feel safe at home? ☐YES ☐NO

Please let your provider know if you have any questions about our ***Patients Bill of Rights***.

Treatment is often conducted in the open gym. Please let your provider know if you are ever uncomfortable with this.

CONDITIONS – Check all that apply to *you and your immediate family* – please indicate who:

☐AIDS	☐Emphysema	☐Liver Disease
☐Anemia	☐Epilepsy	☐Migraines
☐Arthritis	☐Glaucoma	☐Mononucleosis
☐Asthma	☐Gout	☐Multiple Sclerosis
☐Bleeding Disorder	☐Heart Disease	☐Pacemaker
☐Cancer	☐Hepatitis	☐Pneumonia
☐Cataracts	☐Hernia	☐Polio
☐Chemical Dependency	☐High Cholesterol	☐Stroke
☐Diabetes	☐HIV Positive	☐Tuberculosis
☐Eating Disorder	☐Kidney Disease	☐Other: _____

SYMPTOMS – check all that currently *apply to you.*

☐Bruising Easily	☐Fainting	☐Numbness
☐Bowel Changes	☐Forgetfulness	☐Poor Circulation
☐Chest Pain	☐Headache	☐Sleeplessness
☐Decreased Hearing	☐High Blood Pressure	☐Sweats
☐Depression	☐Irregular Heartbeat	☐Swelling in Ankles
☐Difficulty Swallowing	☐Jaw Pain	☐Vision Problems
☐Dizziness	☐Low Blood Pressure	☐Weight Gain

MUSCULOSKELETAL SYMPTOMS – check all that **apply to you** – pain, weakness, or numbness in:

☐Back	☐Hips	☐Neck
☐Elbows	☐Knees	☐Shoulders
☐Feet	☐Legs	☐Wrist

☐Other: _____

SIGNATURE – The information I have provided about my medical history is correct to the best of my knowledge:

Signature: _____

Date: _____	***Date:*** _____
Date: _____	***Date:*** _____
Date: _____	***Date:*** _____
Date: _____	***Date:*** _____
Date: _____	***Date:*** _____

STAFF USE ONLY Any Learning Barriers Noted?

Date: _____ ☐YES ☐NO	Date: _____ ☐YES ☐NO
Date: _____ ☐YES ☐NO	Date: _____ ☐YES ☐NO
Date: _____ ☐YES ☐NO	Date: _____ ☐YES ☐NO