Past Medical History Questionnaire

Patient Name ____

Have you ever received therapy before? YES NO

If so, when? ____

Could you be or are you pregnant? YES NO

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

	YES	NO		YES	NO
Arthritis	_____	_____	Metal Implants	_____	_____
Osteoporosis	_____	_____	Cancer/Tumor	_____	_____
High Blood Pressure	_____	_____	Recent Weight Loss/Gain	_____	_____
Heart Disease	_____	_____	Current Infection(s)	_____	_____
Heart Attack	_____	_____	Tuberculosis	_____	_____
Pacemaker	_____	_____	Hepatitis	_____	_____
Vascular Disease	_____	_____	Thyroid Problems	_____	_____
Stroke	_____	_____	Headaches	_____	_____
Asthma	_____	_____	Head Injury/Concussion	_____	_____
Shortness of Breath	_____	_____	Hernia	_____	_____
Chronic Cough	_____	_____	Kidney/Bladder Problems	_____	_____
Fainting Spells	_____	_____	Previous Fractures	_____	_____
Diabetes	_____	_____	Previous Surgeries	_____	_____
Anemia	_____	_____	Hearing Loss	_____	_____
Hypersensitivity			Depression	_____	_____
To Heat/Cold	_____	_____	Anxiety	_____	_____
Swelling in Ankles	_____	_____	Substance Abuse	_____	_____
Seizures/Epilepsy	_____	_____	Allergies	_____	_____
Deep Vein Thrombosis	_____	_____	Other	_____	_____

If you answered "yes" to any of the above, please explain and give approximate date(s):

____

____

____

Are you presently taking any medications? If "yes", list all medications.

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The information above is correct to the best of my knowledge.

____ ____________

Patient/Parent/Guardian Signature Date