Box Below For Office Use:

Pain	
BMI	
LEFS	
Dash	
M. Oswestry	
Neck	
Dizziness	
Jaw	

Medical History (Information Below for Patient to Complete)

Name:_____ **Date Of Birth:** _____**Date:** _____

Height:_____ **Current Weight**:_____

Medical History (Check all that apply)

☐ Angina	☐ Hepatitis	☐ Migraines/HA	☐ Cancer
☐ Arrhythmia	☐ Head Injury	☐ Osteoarthritis	☐ Diabetes
☐ MI/Heart Attack	☐ HIV/AIDS	☐ Rheumatoid Arthritis	☐ Asthma
☐ Stroke/CVA	☐ Kidney Disease	☐ Osteopenia	☐ Fractures
☐ TIA/mini stroke	☐ Metal Implants	☐ Osteoporosis	☐ Pacemaker
☐ High Cholesterol	☐ Emphysema	☐ Total Knee	☐ Vision/Hearing
☐ High Blood Pressure	☐ Chronic Bronchitis	☐ Total Shoulder	☐ Total Hip
☐ Other Heart Disease	☐ Epilepsy/Seizures	☐ Pregnant (Wks)	☐ Spinal Cord Injury

Do you have any allergies? Specify:_____

Any other medical problems?

If yes, please specify:_____

Surgeries/Hospitalizations:

Surgery Type Hospital Dates

1. _____
2. _____
3. _____

Current prescription, over the counter medications and/or nutritional supplements:

_____

_____