



Medical History Form

Name: _____ Date of Birth: _____ Date: _____
 Occupation: _____ Date of Injury: _____ Auto: ___ YES ___ NO
 Work Accident: ___ YES ___ NO Related Surgery: _____ Activity Level: _____

Past Medical History (please check boxes below):

Do you have a history of:

- High blood pressure
- Diabetes
- Pacemaker
- Heart Disease
- Cancer
- _____
- Smoker

- TIA/CVA (Stroke)
- Recent Fracture
- Osteoarthritis
- Rheumatoid Arthritis
- History of falls
- Allergies

- Headaches
- Seizures
- Fibromyalgia
- Lupus
- Hyper/Hypoglycemia
- Special Diet Guidelines: _____
- _____

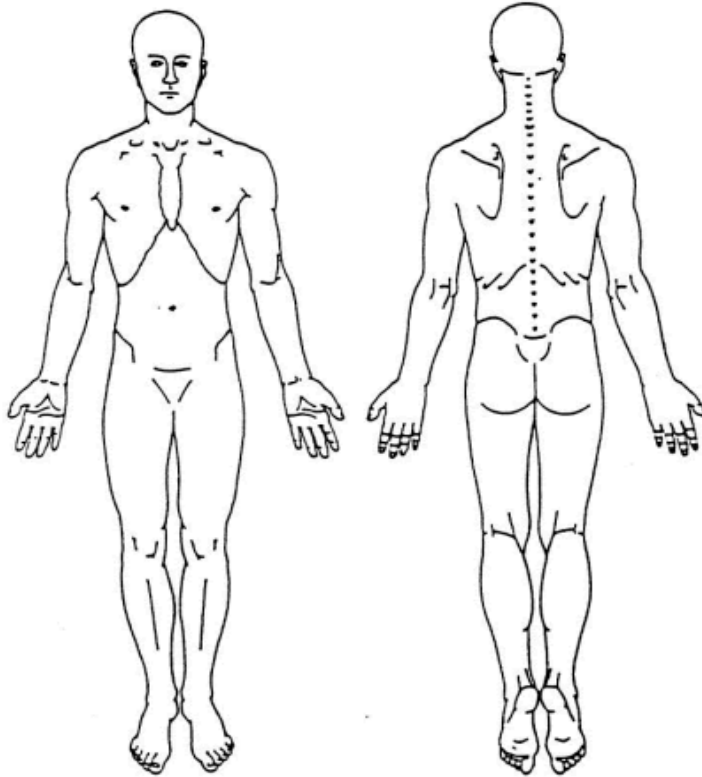
Please list any additional medical conditions not listed above: _____

Surgical history: _____

Body Diagram

Instructions:

On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition,



Pain Description Chart (please use on body diagram above):	
Sharp Pain	XXXXXXXXXX
Pins/Needles	//////////
Burning/Aching	VVVVVVVV
Tenderness	+++++++
Radiating Pain	~~~~~

Please rate your pain level (0= no pain, 10= worst pain imaginable)

Current pain level: _____ Pain at best/rest: _____ Pain at worst: _____

Pain when sleeping: _____ YES _____ NO

Is your pain rapidly changing? _____

Signature of Patient/Guardian: _____

Date: _____