



General Patient Medical History

Date: _____

Patient Last Name: _____ First Name: _____ Middle Initial: _____

Occupation: _____ Age: _____ Handed: Right Left

Have you ever had any of the following diseases or problems? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcer Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Other: _____ | |

Review of Symptoms Currently Present – please check all that apply.

- | | | | | |
|---------------|--------------------------------------|--|-----------------------------------|---------------------------------|
| General – | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Fever | <input type="checkbox"/> Chills |
| Respiratory – | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | | |
| Abdominal – | <input type="checkbox"/> Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | |
| Extremities – | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Numbness | <input type="checkbox"/> Weakness | |

Have you ever had previous neck or back injuries? Yes No

If yes, please explain: _____

Please list other surgeries you've had: _____

Are you pregnant? Yes No

Do you smoke cigarettes / cigars? Yes No # Packs Per Day _____ How Many Years Have You Smoked? _____

Do you drink alcoholic beverages? Yes No

Have you ever had a problem with drug or alcohol abuse? Yes No

Do you have any hobbies that may have contributed to your current problem(s)? _____

Do any diseases run in your family such as diabetes, cancer, heart disease, high blood pressure, scoliosis, rheumatoid arthritis, low back or neck pain, etc.? _____