Past Medical History Questionnaire

Patient Name			Date of Birth	
Reason for Therapy		Date of Inquiry or Onset		
Have you ever received therapy for the condition mentioned above? □ Yes □ No		If so when?		
Treatment Received		Previous Treatment:□ Successful □Unsuccessful		
Could you be or are you pregnant? □ Yes □ No				
Do you now or have you ever had any of the following?				

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

If you answered 'Yes' on any of the above, please explain and give approximate date(s):	
Do you have any allergies? □ No □ Yes, list allergies	
Are you presently taking any medications? □ No □ Yes, list medications and specify condition	
The information is correct to the best of my knowledge	
x	
Patient/Parent/Guardian Signature	Date