



\*\*Please indicate which diagnostic procedures/test you have had and the approximate date and location where the test was performed.

	DATE	LOCATION
_____ X-RAY	_____	_____
_____ CT SCAN	_____	_____
_____ MRI	_____	_____
_____ EMG	_____	_____
_____ NERVE CONDUCTION	_____	_____
_____ DISCOGRAM	_____	_____
_____ MYLOGRAM	_____	_____

\*\*Have you had any injections, procedures, or surgeries in the past year ***FOR THIS PROBLEM?*** YES or NO

\*\*If yes, what did you have done, when was it done, and by which physician? \_\_\_\_\_  
 \_\_\_\_\_

\*\* Have you participated in any of the following treatments ***FOR THIS PROBLEM*** in the last two years?

Type of Treatment	Participated?	Pain Relief	Approximate Date	Still participating?
Physical Therapy	Yes No	Yes No Somewhat		Yes No
Chiropractor	Yes No	Yes No Somewhat		Yes No
Home Exercises	Yes No	Yes No Somewhat		Yes No
Traction	Yes No	Yes No Somewhat		Yes No
Tens Unit	Yes No	Yes No Somewhat		Yes No
Acupuncture/Dry Needling	Yes No	Yes No Somewhat		Yes No
Physiatrist / Psychologist	Yes No	Yes No Somewhat		Yes No
Hypnosis	Yes No	Yes No Somewhat		Yes No
Massage		Yes No Somewhat		Yes No

\*\*How long have you had this pain?: \_\_\_\_\_

\*\*Did this pain come on gradually or suddenly? \_\_\_\_\_

\*\*State the reason you think caused this pain. If unknown, write unknown. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICAL HISTORY**

**List all allergies** you have to medications, products, and/or foods: \_\_\_\_\_

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**Do you currently have, have had in the past, or are taking medication for the following conditions? (please circle)**

**CARDIOVASCULAR:** A-fib    Anemia    Aneurysm    Blood Clot    Cellulitis    Chest pain  
Congestive Heart Failure    Heart Attack    Heart Disease    Heart murmur    High blood pressure  
High cholesterol    Irregular heart beat    Mitral Valve Prolapse    Stroke    TIA (mini stroke)

**ENDOCRINE:**

Diabetes Type 1    Diabetes Type 2    Goiter    Hyperthyroidism    Hypothyroidism    Pancreatitis

**GASTRO INTESTINAL:**    Acid Reflux (GERD)    Cirrhosis    Constipation    Crohn's    Diarrhea  
Diverticulitis    Gallstones    Hemorrhoids    Hepatitis (which one?\_\_\_\_)    Hernia    Irritable Bowel  
Liver Problems    Ulcer

**RESPIRATORY:**    Chronic Bronchitis    COPD    Shortness of Breath    Seasonal Allergies    Sleep Apnea

**GENTOURINARY/REPRODUCTIVE:**

Benign Prostatic Hypertrophy (BPH)    Endometriosis    Erectile dysfunction    Kidney/Renal disease    Kidney Stones  
Low testosterone    Painful periods    Polycystic ovaries    Urinary Incontinence    Urinary Tract Infections

**MUSCULOSKELATAL:**

Bursitis    Degenerative Disc Disease    Degenerative Joint Disease    Fibromyalgia    Gout    Kyphosis  
Osteoarthritis    Osteomyelitis    Osteopenia    Osteoporosis    Rheumatoid Arthritis    Scoliosis

**PSYCHOLOGICAL/NEUROLOGICAL**

ADD or ADHD    Addiction    Alcoholism    Alzheimer's Disease    Anxiety/Panic Attacks    Bell's Palsy    Bipolar  
Brain Injury    Dementia    Depression    Dizziness    Headaches    Hearing Loss    Insomnia  
Memory Issues    Migraines    Parkinson's Disease    PTSD    Restless Leg Syndrome    Schizophrenia  
Seizures/Epilepsy    Shingles    hx. of Spinal Meningitis    Substance Abuse    Vertigo  
Suicidal Thoughts    Vision Problems (cataracts, legally blind)

**OTHER:**    hx. of MRSA    HIV/AIDS    Lyme's disease    Malignant Hyperthermia    Bleeding disorder

List any conditions you have that are not mentioned above \_\_\_\_\_

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**FAMILY HISTORY**

Do any of your immediate family (parents, children, siblings) have any of the conditions above? If so, please write them below. \_\_\_\_\_

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