Medical History

Name_____ Today's Date_____

Height_____ Weight_____

Have you ever had/or currently have any of the following:

	Yes	No
1. Cerebrovascular Accident	☐	☐
2. Cauda equine Syndrome	☐	☐
3. Cardiovascular / Heart Disease	☐	☐
4. Current Infections:_____	☐	☐
5. Diabetes: Type I or II	☐	☐
6. Fibromyalgia	☐	☐
7. Irritable Bowel Syndrome	☐	☐
8. Chronic Fatigue Syndrome	☐	☐
9. Current fractures or suspected fractures: _____	☐	☐
10. High Blood pressure	☐	☐
11. Gastrointestinal disorders:_____	☐	☐
12. History of cancer:_____	☐	☐
13. Huntington's Disease	☐	☐
14. Immunosuppressive Disorders: _____	☐	☐
15. Lupus	☐	☐
16. Multiple Sclerosis	☐	☐
17. Muscular Dystrophy	☐	☐
18. Osteoarthritis: Areas impacted:_____	☐	☐
19. Parkinson's Disease	☐	☐
20. Previous Surgeries:_____	☐	☐
21. Psoriatic Arthritis. Areas impacted:_____	☐	☐
22. Rheumatoid Arthritis. Areas impacted:_____	☐	☐
23. Traumatic Brain Injury	☐	☐
24. Osteoporosis/penia. Areas impacted:_____	☐	☐

Do you:

25. Smoke or regularly use smokeless tobacco
26. Suffer from anxiety or depression

If yes, please circle answer that best describes following statements:

a. "I feel sad or depressed"

Never Rarely Sometimes Often Always

b. How much have you been bothered by feeling depressed in the past week

Never Rarely Sometimes Often Always

27. Do you sleep disturbances or difficulty in sleeping?

If yes, please circle answer below that best describes following statements:

a. I feel tired and unrefreshed when I wake from sleeping

Never Rarely Sometimes Often Always

b. In the past 24 hours how often has has pain interfered with your sleep?

Never Rarely Sometimes Often Always

List all medications currently taking:

_____

_____

_____

_____