Patient Name: ____ Date: ________________________________

Sex: M F Referring Physician: ______________________ Occupation: _________________________

<u>PRESENT CONDITION</u>:

Present Problem: ____

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Date of Injury: ______________________ Date of Follow-up with MD: ______________________________

Were X-rays taken? Y N When? ____

Was MRI taken? Y N When? ____

Is this a recurring problem? ____

Do you have a history of?

Condition		
Diabetes	Y	N
Arthritis	Y	N
Cardiac condition	Y	N
High blood pressure	Y	N
Cancer	Y	N
Osteoporosis	Y	N
Seizures	Y	N
Numbness/Tingling	Y	N
Asthma	Y	N

Question		
Are you latex sensitive?	Y	N
Are you pregnant?	Y	N
Do you smoke?	Y	N

Please list any medications you are taking:

1____

2____

3____

4____

5____

SURGERIES:

1____

2____

Please list any allergies:

1____

2____

3____

Any other medical conditions we should know about? ____

____

Patient Signature: ____