

Medical History Questionnaire

Patient Name Birth Age Reason for Therapy Oate of Injury Or Onset Are you currently receiving any other care for the condition mentioned above? No Yes if yes, please list: Have you ever received therapy in the past for the condition mentioned above? No Yes if yes, please list: Have you received therapy services for other problems/conditions this calendar year? No Yes if yes, please list: Can you be or are you program!? No Yes No Yes No Yes No Do you now rhave you ever had any of the following conditions: Condition Yes No Yes No Yes No Do you now rhave you ever had any of the following conditions: Condition Yes No Condition Yes No Attritis Condition Yes No Condition Yes No Invoid Problems Condition High Blood Pressure Condition sergen with the past for the p	Patient Name Birth Age Reason for Therapy Date of Injury or Onset For You currently receiving any other care for the condition mentioned above? No Yes If yes, please Have you ever received therapy in the past for the condition mentioned above? No Yes If so, when's Previous Treatment Previous Treatment Successful Unsi Received: Previous Treatment Successful Unsi Can you be or are you pregnant? No Yes No Yes Do you now or have you ever had any of the following conditions? Numbness/Tingling Numbness/Tingling Condition Yes No Condition Yes Arthritis Diabetes Numbness/Tingling Gsteoporsis Anemia Fever/Chilis Headches Heart Disease Seizures/Epilepsy Headches Headches Head Vascular Disease Metal in Body or Surgicat Previous Surgeries Evelowed Surgeries <t< th=""><th></th><th colspan="4"></th><th colspan="2">Date of</th><th></th><th></th><th></th><th></th></t<>						Date of						
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