# PATIENT HISTORY



**Please list all previous treatments for this condition:**

Name of Treating Physician _____ Dates of Treatment _____
Type of Treatment or Drugs Prescribed _____

Name of Treating Physician _____ Dates of Treatment _____
Type of Treatment or Drugs Prescribed _____

**Please list all past surgeries:**

Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type When Doctor

**Please list all previous auto accidents, accidents and falls (**even if sought NO treatments for it) **:**

What _____ When _____
What _____ When _____
What _____ When _____
What _____ When _____

**Please list any medications or vitamins you are currently taking:**

_____
_____
_____

## Other problem areas: check off… or make 'yes' or 'no'

- ☐ Insomnia
- ☐ Fatigue
- ☐ Stress
- ☐ TMJ
- ☐ Shoulder Problems
- ☐ Elbow / Elbow pain
- ☐ Leg Problems
- ☐ Knee Problems
- ☐ Foot Problems
- ☐ Disc Problems
- ☐ Arthritis
- ☐ Scoliosis

Any Immune Problems? Y / N
Any Eye, Ear, Nose, or Throat? Y / N
Any Heart Problems? Y / N
Any Lung Problems? Y / N
Any Breast Problems? Y / N
Any Urinary Problems? Y / N
Any Thyroid or Diabetes? Y / N
Any Mental – Emotional issues? Y / N
Any Allergies? Any Asthma? Y / N
List other conditions you think are relevant:_____
_____
_____

PATIENT SIGNATURE _____DATE _____