Past Medical History

Patient Name:		**Date of Birth:**	
Reason for Therapy:		**Date of Onset:**	
Problems Associated with Current Problem:			
What Treatments have You Had For This Problem?		**Date:**	

Are You or could You Currently Be Pregnant?	**Yes No**	**Precautions:**

Do You Now or Have You Ever Have Any of the Following Conditions?

Condition:	*Yes*	*No*	*Condition:*	*Yes*	*No*	*Condition:*	*Yes*	*No*
Heart Disease			**Current/Recent Infections**			**Cancer**		
Heart Attack			**Diabetes**			**Tumors**		
Pacemaker			**Hypoglycemia**			**Recent Weight Gain/Loss**		
High Blood Pressure			**Fainting Spells**			**Hernia**		
Stroke			**Anemia**			**Tuberculosis**		
Seizures/Epilepsy			**Arthritis**			**Hepatitis**		
Vascular Disease			**Osteoporosis**			**Kidney/Bladder Problems**		
Deep Vein Thrombosis (DVT)			**Head Injuries**			**Substance Abuse**		
Asthma			**Concussion**			**Depression**		
Respiratory Disease			**Metal or Surgical Implants**			**Anxiety**		
Chronic Cough			**Thyroid Problems**			**Hearing Loss**		
Shortness of Breath			**Hypersensitivity to Cold/Heat**			**Learning Disabilities**		

Please Explain if You Answered "Yes" to Any of the Above Questions

Other Conditions/Problems:	
Previous Fractures or Surgeries:	
Medications:	
Allergies:	

The Above Information is Correct to the Best of my Knowledge.

Patient/Guardian Signature:	**Date:**