

13. Who have you seen for your symptoms? ①No One ③Chiropractor ⑤Other
 ②Medical Doctor ④Physical Therapist _____

a. What treatment did you receive and when? _____

14. What tests have you had for your symptoms and when were they performed? ①X-rays date:____ ③CT Scan date:____
 ②MRI date:____ ④Other date:____

a. Did you have surgery? Yes No Date of Surgery if applicable: __/__/__

15. Have you had similar symptoms in the past? Yes No

a. If you have received treatment in the past for the same or similar symptoms, who did you see? ①No One ③Chiropractor ⑤Other
 ②Medical Doctor ④Physical Therapist _____

16. What is your occupation? ①Professional/Executive ④Laborer ⑦Retired
 _____ ②White Collar/Secretarial ⑤Homemaker ⑧Other
 ③Tradesperson ⑥FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status? ①FT ③Self-Employed ⑤Off Work
 ②PT ④Unemployed ⑥Other

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure (401.9)
<input type="checkbox"/>	<input type="checkbox"/>	Angina (413.9)
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack (410.9)
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (436)
<input type="checkbox"/>	<input type="checkbox"/>	Asthma (493.9)
<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS (042)
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (199.1) Location: _____ date: __/__/__
<input type="checkbox"/>	<input type="checkbox"/>	Tumor (229.9)
<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus (710.0)
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (573.3)
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (349.5)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (250.0)
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis (714.0)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (716.9)
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco (305.1) packs/day _____
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence (303.9)
<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffeine drinks: cups/cans per day _____

Do you have a permanent disability rating? <input type="checkbox"/> YES <input type="checkbox"/> NO Location _____ _____ Date rating received __/__/__ Rating Percentage _____%
Hospitalization/Surgical Procedures (list if not described elsewhere): _____ _____ _____ Medications: _____ _____ _____ Present: Weight _____ Height: Feet _____ Inches _____

Patient Name _____ Date _____