Box below for Office Use:

Pain		**Neck**	
BMI		**Dizziness**	
LEFS		**Jaw**	
Dash		**Tinetti Balance**	
Knee		**EASI**	
M. Oswestry		**PHQ-9**	

Medical History (Information Below for Patient to Complete)

Name: _____ **Date of Birth:** _____ **Date:** _____

Height: _____ **Current Weight**: _____

Medical History (Check all that apply)

☐ Angina	☐ Hepatitis	☐ Migraines/HA	☐ Cancer
☐ Arrhythmia	☐ Head Injury	☐ Osteoarthritis	☐ Diabetes
☐ MI/Heart Attack	☐ HIV/AIDS	☐ Rheumatoid Arthritis	☐ Asthma
☐ Stroke/CVA	☐ Kidney Disease	☐ Osteopenia	☐ Fractures
☐ TIA/mini stroke	☐ Metal Implants	☐ Osteoporosis	☐ Pacemaker
☐ High Cholesterol	☐ Emphysema	☐ Total Knee	☐ Vision/Hearing
☐ High Blood Pressure	☐ Chronic Bronchitis	☐ Total Shoulder	☐ Total Hip
☐ Other Heart Disease	☐ Epilepsy/Seizures	☐ Pregnant (Wks)	☐ Spinal Cord Injury

Do you have any allergies? Specify: _____

Any other medical problems?

If yes, please specify:

_____

Surgeries/Hospitalizations:

	Surgery Type	**Hospital**	**Dates**
1.			
2.			
3.			

Current prescription, over the counter medications and/or nutritional supplements:

_____

_____