HIGH DESERT PHYSICAL REHABILITATION GROUP

MEDICAL HISTORY FORM

Name: _____ Physician: _____
Sex: _____ DOB: _____ Age: _____ SSN: _____
What problems bring you to therapy? _____

_____

Date/Onset of Injury? _____ Date of surgery? _____
How did the injury occur? _____

_____

_____

Have you had previous therapy for your present condition? If yes, when and where? _____

_____

_____

Have you had previous Chiropracic care for your present condition? If yes, when and where? _____

_____

_____

_____

How has your current condition affected your ability to perform each of the following abilities? For each of the activities listed below, please place a check mark in the column if you are unable to complete the activity and a brief description of your limitations of the activity.

| Activity | ✓ | | Activity | ✓ | |
|---|---|---|---|---|---|
| Sleeping | | | Climbing | | |
| In & out of tub/shower | | | Using Stairs | | |
| Bathing | | | Using Hand Tools | | |
| Dressing | | | Liftinbg | | |
| Grooming | | | How many lbs? | | |
| Prepared Meals | | | Carrying | | |
| Household Chores | | | Pushing | | |
| Child Care | | | Pulling | | |
| Shopping | | | Reaching | | |
| Writing | | | Stooping/squatting | | |
| In & out of car | | | Kneeling/crawling | | |
| Driving | | | Work Activities | | |
| Walking: level terrain | | | Hearing | | |
| Walking: uneven terrain | | | Speaking | | |
| Standing | | | Remembering | | |
| Sitting | | | Eating/Swallowing | | |

Please continue on other side... ⇨

What are your primary goals for therapy? _____

_____

_____

_____

Do you have now or have you previously had any of the following?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | Previous Surgeries | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Fractures | ☐ | ☐ |
| Heart Problems | ☐ | ☐ | Sprains/Strains | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | Pregnancy | ☐ | ☐ |
| Dizzy Spells | ☐ | ☐ | Arthritis | ☐ | ☐ |
| Stroke | ☐ | ☐ | Hearing Disorders | ☐ | ☐ |
| Seizures | ☐ | ☐ | Vision Problems | ☐ | ☐ |
| Breathing Disorders | ☐ | ☐ | Back Problems | ☐ | ☐ |
| _____ | ☐ | ☐ | Cancer | ☐ | ☐ |

If you answered YES to any of the above, please explain and give approximate dates: _____

_____

_____

_____

Do you have any other medical or physical problems? _____

_____

_____

_____

What medications are you taking (name, dosage, frequency)?(including those not related to your current condition, over the counter and vitamins) _____

_____

_____

_____

What allergies do you have, if any? _____

_____

_____

Do you have a DNR? _____Yes _____No If yes, please provide a copy for our office.

_____ _____

Signature Date

REVISED 3/06