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| **Medical History Form** |

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| Medical History Form |
| **GENERAL INFORMATION** |
|  |  |  |  |
| Name:       |  Client #       |  Date:       |
| Address:       |
| City:       |  State:       |  Zip:       |
| Telephone: Home: (   )       |  Cell: (   )       |
| Age:       Sex:       Height:       Weight:       |
| Physician:       |  Location: Diagnosis:      |
| Date of Injury or Condition Onset:       |
| Insurance Carrier:       | Claim No:       |
| Claims Adjuster:       | Phone No: (   )       |

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|  | Has your doctor ever said you have any cardiovascular problems? | [ ]  Yes | [ ]  No |
|  | Do you frequently suffer from chest pains? | [ ]  Yes | [ ]  No |
|  | Have you ever had a heart attack? | [ ]  Yes | [ ]  No |
|  | Do you ever experience an irregular or racing heart rate during exercise or at rest? | [ ]  Yes | [ ]  No |
|  | Do you often feel faint or have spells of severe dizziness? | [ ]  Yes | [ ]  No |
|  | Has a doctor ever said that your blood pressure is too high? | [ ]  Yes | [ ]  No |
|  | Do you often have difficulty breathing? | [ ]  Yes | [ ]  No |
|  | Has a doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise, or might be aggravated with exercise? | [ ]  Yes | [ ]  No |
|  | Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to? | [ ]  Yes | [ ]  No |
|  | Are you over age 65 and not accustomed to vigorous exercise? | [ ]  Yes | [ ]  No |
|  | Are you a diabetic? | [ ]  Yes | [ ]  No |
|  | Are you pregnant? | [ ]  Yes | [ ]  No |
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| **Medical History Form** |

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| **MEDICAL INFORMATION** |
|  | Date of last physician visit:       |
|  | List any medications you are now taking and the reason for which they were prescribed:       |
|  | Describe your condition: |
|  | List any surgical procedures you have undergone and date of procedure: |
|  | Have you received physical therapy or chiropractic care? If so when and with whom? |
|  | Have you or any member of your immediate family (mother, father, sister or  |
|  | brother) been diagnosed with: | Heart Disease:       |
|  | Diabetes:       | Hypertension:       |
|  | Stroke:       | High Cholesterol:       |
|  | Obesity:       | Hyperthyroidism:       |
|  | How many hours a week do you work? [ ]  20 [ ]  30 [ ]  40 [ ]  50 |
|  | How do you spend most of your time at work? |
|  |  [ ]  Sitting [ ]  Standing [ ]  Carrying Loads [ ]  Driving [ ]  Walking |
|  | Do you smoke? [ ]  Yes [ ]  No |  |  |
|  | How many times per week do you engage in moderate or strenuous exercise for at least 30 minutes? [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  >5 |
|  | Do you have any pain when exercising? If yes, rate on a scale of 1–10.       |
|  |  |
| Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:       |
| **In case of emergency, notify the following person:** |
| Name: |       | Phone: | home |       |
| Address: |       |  | work |       |