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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: (   ) | | | | | | |
|  | | | | |
|  | | 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 |  | | |