

11. What tests have you had for your symptoms (check all that apply)?

None X-rays MRI CT scan Other: _____

12. What is your occupation? _____ Are you: Full time Part Time Off Work

13. Self Employed? Yes No

Any Current Work Limitations? (Light duty and/or physician ordered limitations): No Yes
(Please List)

14. Past Medical History: Please check each condition that you have been told you have:

Diabetes	Asthma	Lung Disease	Kidney Disease	Angina/Chest Pain
Stroke	Fibromyalgia	Heart Disease	Pacemaker	High Blood Pressure
Cancer	Osteoporosis	Arthritis	Other: _____	
Depression	Anxiety			

HEIGHT: _____ WEIGHT: _____

15. Please List significant injuries and/or surgeries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury & surgery:

16. Please list (**or provide a copy**) of prescription medications and/or over the counter meds you are taking:

17. What are your goals in coming for treatment?

18. List any Allergies: _____

19. Are you allergic to Latex? No Yes

20. Have you fallen in the Past Year? No Yes How many times: _____

21. Do you use an assistive device? No Yes What type: _____

22. Who is your referring Doctor? _____ Family Doctor? _____

23. When is your next Doctor appointment (with referring doctor)? _____

Patient Signature: _____ Today's Date: _____