



Medical History and Systems Review

Name _____ Date _____

D.O.B. _____ Age _____ Female () Male ()

Has your height or weight changed in recent months/years? _____

Overall Physical Condition: Poor Fair Good

Excellent

Occupation _____

Leisure Activities _____

Do you exercise beyond normal daily activities and chores? Yes No

Describe the exercise (include how often and how long): _____

Describe the reason for your visit: _____

Date of Injury/Onset _____ Onset (check one): Gradual

Sudden

How did the problem occur? _____

Describe the pain: Dull Sharp Constant Intermittent

Sore Throbbing Bruised Burning

Have you had any similar problems in the past? Please describe: _____

Are you CURRENTLY seeing any of the following?

Table with 3 columns: Professional, YES, NO. Rows include Medical Doctor, Osteopath, Dentist, Physical Therapist, Psychiatrist/Psychologist, and Chiropractor.

If you have been seen by any of the above in the past three months, please describe the reason (ex. illness, physical exam, medical condition): _____

Please list any surgeries or conditions for which you have been hospitalized and the approximate dates and reasons:

Table with 2 columns: Date, Surgery/Hospitalization/Reason. Includes four rows for data entry.

InsideOut

B O D Y T H E R A P I E S

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains, strains) and the approximate date of injury:

Date	Injury
_____	_____
_____	_____
_____	_____
_____	_____

Which of the following OVER THE COUNTER medications have you taken in the past week?

- | | |
|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Advil/Motrin/Ibuprofen | <input type="checkbox"/> Laxatives |
| <input type="checkbox"/> Decongestants | <input type="checkbox"/> Antacids |
| <input type="checkbox"/> Vitamins/Mineral supplements | <input type="checkbox"/> Antihistamines |
| <input type="checkbox"/> Other _____ | |

Please list all PRESCRIPTION medications you are currently taking: _____

Have you ever been DIAGNOSED as having:

- | | | |
|---|---|---|
| ___ Cancer
Type _____
___ Heart Problems
___ High Blood Pressure
___ Angina/Chest Pain
___ Blood clots/Phlebitis
___ Allergies/Asthma
___ Emphysema/C.O.P.D.
___ Chemical Dependency
___ Thyroid Problems
___ Diabetes
___ Multiple Sclerosis
___ Parkinson's
___ Head Injury
___ Headaches/Migraines
___ Rheumatoid Arthritis
___ Osteoarthritis | ___ Depression/Anxiety
___ Psychiatric Disorders
___ Vision/Hearing Disorders
___ Infectious Diseases
___ Hepatitis
___ Tuberculosis
___ HIV/AIDS
___ Other
___ Digestive Disorders
___ GERD
___ Ulcers
___ Bowel Problems
___ Skin Problems
___ Stroke/TIA
___ Kidney Problems/Disease | ___ Urinary/Bladder Control
___ Anemia
___ Epilepsy/Seizures
___ Tendonitis
___ Bursitis
___ Back Problems
___ Knee Problems
___ Hip Problems
___ Hernia
___ Broken Bones
___ Fibromyalgia
___ Osteopenia
___ Osteoporosis
___ Other |
|---|---|---|

Explain any problems you have checked above: _____

InsideOut

B O D Y T H E R A P I E S

Date of Last Complete Medical Exam: Month _____ Year _____ Physician _____

List any MEDICAL TESTS you have had in the past YEAR: _____

Check any CURRENT symptoms:

- | | | |
|--|--|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Weakness | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Where? _____ | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Fever/Night Sweats | <input type="checkbox"/> Where? _____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Other Pain |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Cough | <input type="checkbox"/> Where? _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Limited Movement |
| <input type="checkbox"/> Coordination Problems | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Where? _____ |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Night Pain |
| <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Where? _____ | <input type="checkbox"/> Where? _____ |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Sprain | |
| <input type="checkbox"/> Where? _____ | <input type="checkbox"/> Where? _____ | |

For Women Only: Are you pregnant? _____ Date of last delivery? _____
 # of Pregnancies _____ # of Vaginal Deliveries _____ # of C-sections _____

Where Is Your Pain?

Please mark on the figures, the areas where you are experiencing pain.

