

MEDICAL HISTORY



Patient Name: _____ DOB: _____

Address: _____

Phone: _____ Email address: _____

Primary Ins Name: _____ Secondary Ins Name: _____

Preferred method of contact for upcoming appointments: ☐ text ☐ email

Have you ever, or are you presently being treated for any of the following problems?

Heart Trouble		Yes		No		Asthma		Yes		No	Do you or have you had any of the following symptoms:																																			
High Blood Pressure						Emphysema																																								
Diabetes						Back Injury																																								
Headaches						Arthritis																																								
Dizzy Spells						Bleeding Disorder																																								
Fainting						Fracture																																								
Epilepsy						Cancer																																								
Stroke						Pacemaker																																								
Pregnancy						Implants/Metal																																								
Seizures						Respiratory Problems																																								
Allergies						Tuberculosis					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Productive Cough</td> <td style="width: 5%;"></td> <td style="width: 10%;">Yes</td> <td style="width: 5%;"></td> <td style="width: 10%;">No</td> </tr> <tr> <td>Coughing Blood</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Weight Loss</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Appetite Loss</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Lethargy</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Night Sweats</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Fever</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Productive Cough		Yes		No	Coughing Blood					Weight Loss					Appetite Loss					Lethargy					Night Sweats					Fever				
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*Specify _____						Hepatitis A/B/C																																								

Date of injury: _____ How did the injury occur? _____

Have you been hospitalized for the present problem? ☐ yes ☐ no If yes, dates: _____

Have you undergone surgery for the problem? ☐ yes ☐ no If yes, dates: _____

Have you had previous treatments for the problem? ☐ yes ☐ no If yes, specify Types/Results of treatment: _____

Are you currently receiving any other health, medical, or chiropractic services or by any other organization or individual at this time? _____

Last Date seen by Physician: _____ Next appointment with Physician: _____

Are you on any medications: ☐ yes ☐ no _____

Have you ever had any of the following for the present condition for which you are going to be treated?

EMG ☐ yes ☐ no CAT Scan ☐ yes ☐ no Myelogram ☐ yes ☐ no

X-Ray ☐ yes ☐ no MRI ☐ yes ☐ no

Would you be interested in purchasing/receiving an eStim unit/TENS unit? ☐ yes ☐ no

Have you ever received PT/OT/Speech Services for your present condition? ☐ yes ☐ no

If YES, where and when? _____

****Medical Disclaimer and Liability:**

During your treatment at RTBTS, you will be educated about certain medical conditions and provided with specialized treatment, including modalities. Information received should not be relied upon as an alternative to the advice of your physician. If you have specific questions/concerns, contact your physician.

By signing this form, you agree to never disregard medical advice, delay physician treatment, or discontinue medical regimes given the information provided @ RTBTS.

By signing this form, you agree that the Therapists and Assistants at TRBTS are not liable for any dangers/damages arising from or related to your treatment.

I believe the above to be true and correct to the best of my knowledge:

Patient (representative) Signature: _____ Date: _____

Therapist Signature: _____ Date: _____