Patient Name: _____ DOB: _____/_____/_____

**Medical History**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Allergies (Latex, Peanuts, etc.) | ☐ Yes | ☐ No | Dizzy Spells | ☐ Yes | ☐ No | Osteoporosis | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No | Emphysema/ Bronchitis | ☐ Yes | ☐ No | Parkinson's | ☐ Yes | ☐ No |
| Anxiety | ☐ Yes | ☐ No | Fractures | ☐ Yes | ☐ No | Permanent Disability Status | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | Gallbladder Problems | ☐ Yes | ☐ No | Rheumatoid Arthritis | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | Seizures | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Infections/ Communicable Diseases (HIV/Aids/ Hepatitis/etc.) | ☐ Yes | ☐ No | Smoke | ☐ Yes | ☐ No |
| Cardiac Conditions | ☐ Yes | ☐ No | Incontinence | ☐ Yes | ☐ No | Strokes | ☐ Yes | ☐ No |
| Cardiac Pacemaker | ☐ Yes | ☐ No | Kidney Problems | ☐ Yes | ☐ No | Taking Blood Pressure Medicine | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No | Metal Implants | ☐ Yes | ☐ No | Thyroid Disease | ☐ Yes | ☐ No |
| Circulation Problems | ☐ Yes | ☐ No | Multiple Sclerosis | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Currently Pregnant | ☐ Yes | ☐ No | | | | Vision Problems | ☐ Yes | ☐ No |
| Depression | ☐ Yes | ☐ No | | | | | | |
| Diabetes | ☐ Yes | ☐ No | | | | | | |

**Describe any other conditions or precautions:**

_____

_____

_____

**Fall History**

Injury as a result of a fall in the past year? ☐ Yes ☐ No Date of fall:_____

Two or more falls in the last year? ☐ Yes ☐ No Date of falls: _____

**Surgical History** ☐ List attached

Body Region: _____ Surgery Type: _____ Date of Surgery: ____/____/____

Body Region: _____ Surgery Type: _____ Date of Surgery: ____/____/____

Body Region: _____ Surgery Type: _____ Date of Surgery: ____/____/____

**Current Medications** ☐ List attached

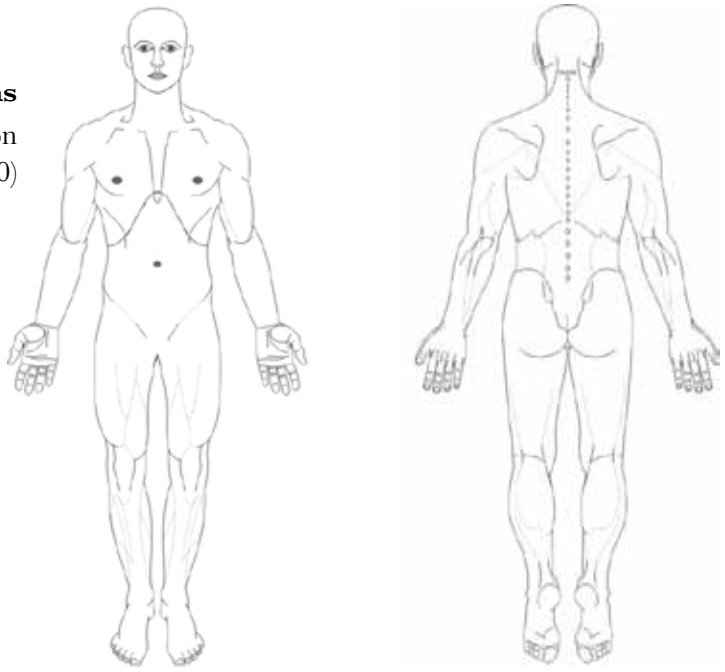
Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

**Pain/Symptoms**

On the body diagram indicate your region of pain and pain level (0-10)



Signature: _____

Print name: _____

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL