

13. Who have you seen for your symptoms? ①No One ③Chiropractor ⑤Other  
 ②Medical Doctor ④Physical Therapist \_\_\_\_\_

a. What treatment did you receive and when? \_\_\_\_\_

14. What tests have you had for your symptoms and when were they performed? ①X-rays date:\_\_\_\_ ③CT Scan date:\_\_\_\_  
 ②MRI date:\_\_\_\_ ④Other date:\_\_\_\_

a. Did you have surgery?  Yes  No Date of Surgery if applicable: \_\_/\_\_/\_\_

15. Have you had similar symptoms in the past?  Yes  No

a. If you have received treatment in the past for the same or similar symptoms, who did you see? ①No One ③Chiropractor ⑤Other  
 ②Medical Doctor ④Physical Therapist \_\_\_\_\_

16. What is your occupation? ①Professional/Executive ④Laborer ⑦Retired  
 \_\_\_\_\_ ②White Collar/Secretarial ⑤Homemaker ⑧Other  
 ③Tradesperson ⑥FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status? ①FT ③Self-Employed ⑤Off Work  
 ②PT ④Unemployed ⑥Other

*If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.*

PAST	PRESENT	
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure (401.9)
<input type="checkbox"/>	<input type="checkbox"/>	Angina (413.9)
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack (410.9)
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (436)
<input type="checkbox"/>	<input type="checkbox"/>	Asthma (493.9)
<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS (042)
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (199.1) Location: _____ date: __/__/__
<input type="checkbox"/>	<input type="checkbox"/>	Tumor (229.9)
<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus (710.0)
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (573.3)
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (349.5)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (250.0)
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis (714.0)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (716.9)
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco (305.1) packs/day _____
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence (303.9)
<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffeine drinks: cups/cans per day _____

Do you have a permanent disability rating? <input type="checkbox"/> YES <input type="checkbox"/> NO Location _____ _____ Date rating received __/__/____ Rating Percentage _____%
Hospitalization/Surgical Procedures (list if not described elsewhere): _____ _____ _____ Medications: _____ _____ _____ Present: Weight _____ Height: Feet _____ Inches _____

Patient Name \_\_\_\_\_ Date \_\_\_\_\_