Present Weight:_____pounds Height:_____feet _____inches

Current Medications:_____
_____
Hospitalizations/Surgical Procedures:_____
_____

Do you have a permanent disability rating? ☐ Yes ☐ No

Location:_____
Date Rating received:_____/_____/_____
Rating percentage:_____%

MEDICAL HISTORY

If you have ever had a listed symptom in the past, please check that symptom in the *Past Column*. If you are presently troubled by a particular symptom, check that symptom in the *Present Column*. KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THEY TYPE OF TREATMENT/THERAPY YOU RECEIVE.

Past	Present	Condition
☐	☐	Neck Pain
☐	☐	Hand Pain (R___L___)
☐	☐	Wrist Pain (R___L___)
☐	☐	Upper Back Pain
☐	☐	Lower Back Pain
☐	☐	Upper Leg/hip Pain (R___L___)
☐	☐	Lower Leg/knee Pain (R___L___)
☐	☐	Pain in ankle or foot (R___L___)
☐	☐	General fatigue
☐	☐	Depression
☐	☐	Dermatitis/eczema/rash
☐	☐	Asthma
☐	☐	Chronic cough
☐	☐	Emphysema (Chronic lung disorder)
☐	☐	Chronic sinusitis
☐	☐	Difficulty in swallowing
☐	☐	Excessive thirst
☐	☐	Diabetes
☐	☐	Headaches
☐	☐	Jaw Pain
☐	☐	Tinnitus (ear noises)
☐	☐	Visual disturbances
☐	☐	Dizziness
☐	☐	Bladder infection
☐	☐	Frequent urination
☐	☐	Painful urination
☐	☐	Prostate problems
☐	☐	Kidney Stones
☐	☐	Kidney disorders (by conditions)_____
☐	☐	Loss of bladder control
☐	☐	Constipation/irregular bowel
☐	☐	Irritable bowel
☐	☐	Colitis

Past	Present	Condition
	☐	☐ Muscular incordination
☐	☐	Swelling/stiffness of joints
☐	☐	Arthritis
☐	☐	Rheumatoid arthritis
☐	☐	Heartburn/indigestion
☐	☐	Number of pregnancies
☐	☐	Heart Attack (date_____)
☐	☐	Aortic aneurysm
☐	☐	Chest pains
☐	☐	High blood pressure
☐	☐	Rapid Heart Beat
☐	☐	Stroke (date_____)
☐	☐	Loss of appetite
☐	☐	Abnormal weight ☐ Gain ☐ Loss
☐	☐	Anorexia/Bulimia
☐	☐	Blood disorder
☐	☐	Tumor, Explain_____
☐	☐	Cancer, Explain_____
☐	☐	HIV/AIDS
☐	☐	Epilepsy
☐	☐	Fainting
☐	☐	Convulsions
☐	☐	Caffeinated drinks: per day____
☐	☐	Drug or alcohol dependence
☐	☐	Tobacco, frequency_____
☐	☐	Alcohol, frequency_____
☐	☐	Birth control pills, type_____
☐	☐	Endometriosis
	☐	☐ PMS
☐	☐	Breast ☐ Soreness ☐ Lumps
☐	☐	Irregular menstrual flow: Profuse__Light__
☐	☐	Number of births
☐	☐	Hepatitis

If a family member has had any of the following, please mark the appropriate box:

☐ Cancer Family member_____ ☐ High blood pressure Family member_____
☐ Chronic back problems Family member_____ ☐ Lung problems Family member_____
☐ Chronic headaches Family member_____ ☐ Lupus Family member_____
☐ Diabetes Family member_____ ☐ Rheumatoid arthritis Family member_____
☐ Heart problems Family member_____

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date