

Present Weight: \_\_\_\_\_ pounds      Height: \_\_\_\_\_ feet \_\_\_\_\_ inches

Current Medications: \_\_\_\_\_ Do you have a permanent disability rating?  Yes  No

Hospitalizations/Surgical Procedures: \_\_\_\_\_ 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 THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Muscular incoordination
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (R__L__)	<input type="checkbox"/>	<input type="checkbox"/>	Swelling/stiffness of joints
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain (R__L__)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Upper Leg/hip Pain (R__L__)	<input type="checkbox"/>	<input type="checkbox"/>	Number of pregnancies _____
<input type="checkbox"/>	<input type="checkbox"/>	Lower Leg/knee Pain (R__L__)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (date _____)
<input type="checkbox"/>	<input type="checkbox"/>	Pain in ankle or foot (R__L__)	<input type="checkbox"/>	<input type="checkbox"/>	Aortic aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	General fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/eczema/rash	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke (date _____)
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (Chronic lung disorder)	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss
<input type="checkbox"/>	<input type="checkbox"/>	Chronic sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia/Bulimia
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder
<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (ear noises)	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Visual disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Caffeinated drinks: per day _____
<input type="checkbox"/>	<input type="checkbox"/>	Bladder infection	<input type="checkbox"/>	<input type="checkbox"/>	Drug or alcohol dependence
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco, frequency _____
<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol, frequency _____
<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	Birth control pills, type _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disorders (by conditions) _____	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Loss of bladder control	<input type="checkbox"/>	<input type="checkbox"/>	Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/irregular bowel	<input type="checkbox"/>	<input type="checkbox"/>	Irregular menstrual flow: Profuse__Light__
<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel	<input type="checkbox"/>	<input type="checkbox"/>	Number of births _____
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	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