

GENERAL HEALTH HISTORY

Check those conditions that apply to you:

GENERAL HEALTH QUESTIONS	PAST or PRESENT ?
Smoke cigarettes or use tobacco products/Asthma/Other lung problems	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Do you have a pacemaker, neck or chest shunt, or problems lying face down?	<input type="checkbox"/>
History of heart attack, chest pain not relieved by rest or circulatory problems	<input type="checkbox"/>
How many hours do you generally sleep per night? Do you feel rested on waking?	<input type="checkbox"/>
I have Dizziness or fainting spell history	<input type="checkbox"/>
Epilepsy-Seizure-Convulsion history	<input type="checkbox"/>
History of gout, lupus, psoriasis, temporary paralysis, or spinal meningitis	<input type="checkbox"/>
Cancer history or treatment (Chemotherapy or Radiation) of any type	<input type="checkbox"/>
Stroke history (Suspected strokes or Other unexplained loss of consciousness)	<input type="checkbox"/>
Told that you have scoliosis, spondylolisthesis, disc degeneration, or herniated disc	<input type="checkbox"/>
Told that you have spina bifida, abdominal aneurysm, or vascular conditions	<input type="checkbox"/>
Have you ever been hospitalized? Why:	<input type="checkbox"/>
Thyroid disorders	<input type="checkbox"/>
I have been in a Coma, suffered a head injury or other loss of consciousness	<input type="checkbox"/>
Told you have osteoporosis or osteopenia ?	<input type="checkbox"/>
Told you have osteoarthritis or rheumatoid arthritis of your spine or joints	<input type="checkbox"/>
Other conditions not previously mentioned?	<input type="checkbox"/>

HISTORY OF INJURY OR PAIN

I have no history of previous injury or pain) If you have had any **prior** injuries or pain, please check below:

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Lifting Injury	<input type="checkbox"/> Head Injury
<input type="checkbox"/> Car/Pedestrian Injury	<input type="checkbox"/> Car accident	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back/Leg Pain	
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Neck Pain or Arm Pain	<input type="checkbox"/> Other (_____) (_____)		

HAVE YOU EVER BROKEN BONES?

If you have broken any bones, indicate where and when: I have never had any broken bones).

Year/Outcome	
<input type="checkbox"/> Spinal Column Fracture	<input type="checkbox"/> Rib Fracture/ Collar bone Fracture
<input type="checkbox"/> Skull Fracture	<input type="checkbox"/> Leg or Foot Fracture
<input type="checkbox"/> Arm or hand Fracture	<input type="checkbox"/> Other Fracture (_____)
<input type="checkbox"/> Pelvis or Hip Fracture	<input type="checkbox"/> Other Fracture (_____)

OR HAD SURGERY ?

If you have had any previous surgery, indicate type and year: I have never had any surgical procedure).

<input type="checkbox"/> Disc surgery in neck or back	<input type="checkbox"/> Hernia/ Abdominal/Pelvic
<input type="checkbox"/> Heart	<input type="checkbox"/> Shoulder/Arm/Leg
<input type="checkbox"/> Cancer (any type)	<input type="checkbox"/> Other (_____)
<input type="checkbox"/> Head/Brain	<input type="checkbox"/> Other (_____)

RECENT OR CURRENT SYMPTOMS OTHER THAN PREVIOUSLY LISTED

SYMPTOM	HOW LONG	SYMPTOM	HOW LONG
<input type="checkbox"/> Headaches		<input type="checkbox"/> Upper Back Pain, Soreness, Stiffness	
<input type="checkbox"/> Neck Pain, Soreness, Stiffness		<input type="checkbox"/> Hip Pain	
<input type="checkbox"/> Low Back Pain, Soreness, Stiffness		<input type="checkbox"/> Leg or Foot Pain, Numbness, Tingling	
<input type="checkbox"/> Arm/Hand Pain, Numbness, Tingling		<input type="checkbox"/> Other	

Form 1300

