

# **ALL SEASONS PATIENT MEDICAL HISTORY FORM**

Patient's Name \_\_\_\_\_ Referring Physician \_\_\_\_\_  
Family Physician \_\_\_\_\_ Date of 1st Doctor's Visit \_\_\_\_\_  
Last day worked due to this injury \_\_\_\_\_ Date returned to work after injury \_\_\_\_\_  
Is an attorney involved in this case? Yes No Have you had surgery for this injury? Yes No  
Type of surgery \_\_\_\_\_ Location of surgery \_\_\_\_\_

**Are you currently taking any prescription or non-prescription medications? Yes No**

Anti-inflammatory Yes No \_\_\_\_\_  
Muscle relaxers Yes No \_\_\_\_\_  
Pain medication Yes No \_\_\_\_\_  
Other Yes No \_\_\_\_\_

**Have you had any of the following medical or rehabilitative services for this injury?**

	Yes	No		Yes	No		Yes	No		Yes	No
Chiropractor	___	___	Occupational Therapy	___	___	CT Scan	___	___	MRI	___	___
General Practitioner	___	___	Physical Therapy	___	___	EMG/NCV	___	___	Myelogram	___	___
Massage Therapy	___	___	Podiatrist	___	___	Emer. Room Care	___	___	X-rays	___	___
Neurologist	___	___		___	___	Injections	___	___		___	___

**Do you have or ever had any of the following?**

	YES	NO		YES	NO		YES	NO
Allergies	___	___	Gout	___	___	Thyroid Trouble/Goiter	___	___
Anemia	___	___	Heart Attack or Surgery	___	___	Varicose Veins	___	___
Arthritis/Swollen Joints	___	___	Hernia	___	___	Vision or Hearing Difficulties	___	___
Asthma, Bronchitis or Emphysema	___	___	High Blood Pressure	___	___	Weakness	___	___
Blood Clots	___	___	Infectious Disease	___	___	Weight Loss/ Energy Loss	___	___
Bowel or Bladder Problems	___	___	Joint Replacement	___	___	Ankle Injury/Surgery	___	___
Cancer/Chemotherapy/Radiation	___	___	Numbness or Tingling	___	___	Back Injury/Surgery	___	___
Coronary Heart Disease or Angina	___	___	Osteoporosis	___	___	Elbow/Hand/Injury/Surgery	___	___
Diabetes	___	___	Pacemaker	___	___	Knee Injury/Surgery	___	___
Dizziness or Fainting	___	___	Severe Headaches	___	___	Pins or Metal Implants	___	___
Emotional/Psychological Problems	___	___	Shortness of Breath	___	___	Pregnant	___	___
Epilepsy/Seizures	___	___	Stroke/TIA	___	___	Do You Smoke	___	___

**Patient/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_