MEDICAL HISTORY

Name:	**DOB:**	Maiden Name/AKA:
Referring MD and Office Location:		
Emergency Contact Name:		Phone:
What is your primary injury/condition?		
Date of Injury or Onset of Pain:		Date of Surgery:
If this is an injury, how did it occur?		
Are you currently working? ❑ **FT** ❑ **PT** ❑ **Not working**		Has this changed since your injury?
What activities do you enjoy?		Has this changed since your injury?
Have you had any imaging done (x-rays, MRI)? ❑ **YES** ❑ **NO**		What type, when?
Have you received any rehabilitative services for this condition or any other since January of this year? ❑ **YES** ❑ **NO**	What type (PT, chiropractic, home health)?	How many visits?
Are you currently taking blood thinners/anticoagulant medications? ❑ **YES** ❑ **NO** Are you currently taking any medications? ❑ **YES** ❑ **NO**		******Please list all medications on next page******
Please rate your pain on a scale of 1 to 10 (0 for no pain, 10 for worst pain):		
Do you have any pins or metal implants? ❑ **YES** ❑ **NO**		Do you have a pacemaker? ❑ **YES** ❑ **NO**
Are you pregnant? ❑ **YES** ❑ **NO**	Do you smoke or vape? ❑ **YES** ❑ **NO**	How much?
Do you drink alcohol? ❑ **Daily** ❑ **Weekly** ❑ **Rarely** ❑ **I do not drink**		
Are you scheduled for any upcoming surgical procedures (describe)? ❑ **YES** ❑ **NO**		

Please check and specify any and all condition(s) you currently have or have had in the past:

❑ Emotional or Psychological Problems	❑ Diabetes	❑ High Blood Pressure
❑ Coronary Heart Disease, Angina	❑ Blood Clot, DVT, Emboli	❑ Dizziness, Lightheaded
❑ Severe or frequent headaches	❑ Heart Attack, Heart Surgery	❑ Vision Difficulties
❑ Asthma, Bronchitis	❑ Emphysema, COPD	❑ Hearing Difficulties
❑ Shortness of Breath	❑ Weight Loss, Weight Gain	❑ Sleeping Difficulties
❑ Stroke, CVA, TIA	❑ Varicose Veins	❑ Epilepsy, Seizures
❑ Thyroid, Goiter	❑ Anemia	❑ Numbness, Tingling
❑ Frequent UTIs	❑ Hernia	❑ Depression, Anxiety
❑ Motor Vehicle Accident (date):	❑ Lyme Disease	❑ Other:

If any of the following apply, please provide specific information:

❑ Muscle weakness:	❑ Arthritis, swollen joints:
❑ Osteopenia, Osteoporosis:	❑ Cancer:
❑ Shoulder injury/surgery:	❑ Joint Replacement:
❑ Neck injury/surgery:	❑ Elbow/Hand injury/surgery:
❑ Back injury/surgery:	❑ Knee injury/surgery:
❑ Bowel or Bladder dysfunction:	❑ Leg/Ankle/Foot injury/surgery:
❑ Allergies:	❑ Infectious Disease:

Please provide any other information you feel would assist us with your care:

*****THIS FORM MUST BE SCANNED INTO THE PATIENT'S EMR*****

MEDICAL HISTORY

CARLSON PROCARE

MEDICATION RECORD SHEET

(Please include prescription and non-medications, vitamins, and dietary supplements)

Name: _____ DOB: _____ Today's Date: _____

Medication	Dosage	Frequency	Route (e.g., Oral)

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