MEDICAL HISTORY

Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures for their effectiveness and your safety. Thank you!

Do you have or have you had any of the following:

Cancer	❒ YES ❒ NO
Diabetes	❒ YES ❒ NO
Epilepsy	❒ YES ❒ NO
Heart Disease	❒ YES ❒ NO
High Blood Pressure	❒ YES ❒ NO
Metal Implants	❒ YES ❒ NO
Respiratory Problems	❒ YES ❒ NO
Psychological Problems	❒ YES ❒ NO
Are you Pregnant?	❒ YES ❒ NO
Do you have Allergies?	❒ YES ❒ NO

If yes, what _____

Please list any additional medical conditions we should be aware of:

Current Medications: _____

Surgeries (What/Where/When): _____

Recent Illness (What/When): _____

Work Related Injury	
Were you injured at work? ❒ YES ❒ NO	Date of Injury (mm/dd/yy):
Name of Compensation Carrier:	Claim #:
Address:	

Auto Related Injury	
Were you injured in a traffic accident? ❒ YES ❒ NO	Date of Accident (mm/dd/yy):
Name of Auto Insurance Carrier:	Ins. Co Phone Number:
Policy #:	Claim #:
Address:	