## Patient Medical Information

**Age** _____ Height (Required): _____ft. in. Weight (Required): _____ lbs.

Please indicate the number of surgeries for your primary condition. [ ] None [ ] 1 [ ] 2 [ ] 3 [ ] 4+

How many days ago did the condition begin? [ ] 0-7 days [ ] 8-14 [ ] 15-21 [ ] 22-90 [ ] 91days to 6 mos [ ] Over 6mos. Ago

Are you taking prescription medication for this condition? [ ] Yes [ ] No
Are you currently taking any other medications? [ ] Yes [ ] No
If 'Yes" list them _____
Have you received treatments for this condition before? [ ] Yes [ ] No

How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? [ ] At least 3 times per week [ ] Once or twice per week [ ] Seldom or never

Do you have or have had any of the following:

[ ] Arthritis (rheumatoid / osteoarthritis)
[ ] Osteoporosis
[ ] Asthma
[ ] Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema, Angina
[ ] Congestive heart failure (or heart disease)
[ ] Heart attack (Myocardial infarction)
[ ] High blood pressure
[ ] Neurological Disease (such as Multiple Sclerosis or Parkinson's)
[ ] Stroke or TIA
[ ] Peripheral Vascular Disease
[ ] Headaches
[ ] Diabetes Types I and II
[ ] Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
[ ] Pace maker
[ ] Seizures
[ ] Visual Impairment (such as cataracts, glaucoma, macular degeneration)
[ ] Hearing Impairment (very hard of hearing even with hearing aids)
[ ] Back pain (neck pain, low back, degenerative disc disease, spinal stenosis
[ ] Kidney, bladder, prostate, urination problems
[ ] Previous Accidents
[ ] Allergies
[ ] Incontinence
[ ] Anxiety or Panic Disorders
[ ] Depression
[ ] Hepatitis, Tuberculosis, HIV, AIDS, other blood borne condition
[ ] Prior Surgery
[ ] Prosthesis/Implants
[ ] Sleep Dysfunction
[ ] Cancer

**If yes to any above, please explain and give approximate dates** _____

_____

This is a statement other patients have made.
"I should not do physical activities which (might) make my pain worse."
[ ] Completely Disagree
[ ] Somewhat Disagree
[ ] Unsure
[ ] Somewhat Agree
[ ] Completely Agree

I certify that the above information is true and correct to the best of my knowledge.

**Patient signature**_____ **Date**_____