Present Weight:________________pounds Height:_________feet __________inches

Current Medications:____
____
Hospitalizations/Surgical Procedures:_______________________________
____

Do you have a permanent disability rating? ☐ Yes ☐ No
Location:_______________________________________
Date Raing received:_________/________/_________
Rating percentage:____________%

MEDICAL HISTORY

If you have ever had a listed symptom in the past, please check that symptom in the *Past Column*. If you are presently troubled by a particular symptom, check that symptom in the *Present Column*. KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THEY TYPE OF TREATMENT/THERAPY YOU RECEIVE.

Past	Present	Condition	Past	Present	Condition
☐	☐	Neck Pain	☐	☐	Muscular incordination
☐	☐	Hand Pain (R___L___)	☐	☐	Swelling/stiffness of joints
☐	☐	Wrist Pain (R___L___)	☐	☐	Arthritis
☐	☐	Upper Back Pain	☐	☐	Rheumatoid arthritis
☐	☐	Lower Back Pain	☐	☐	Heartburn/indigestion
☐	☐	Upper Leg/hip Pain (R___L___)	☐	☐	Number of pregnancies
☐	☐	Lower Leg/knee Pain (R___L___)	☐	☐	Heart Attack (date_________)
☐	☐	Pain in ankle or foot (R___L___)	☐	☐	Aortic aneurysm
☐	☐	General fatigue	☐	☐	Chest pains
☐	☐	Depression	☐	☐	High blood pressure
☐	☐	Dermatitis/eczema/rash	☐	☐	Rapid Heart Beat
☐	☐	Asthma	☐	☐	Stroke (date_____________)
☐	☐	Chronic cough	☐	☐	Loss of appetite
☐	☐	Emphysema (Chronic lung disorder)	☐	☐	Abnormal weight ☐ Gain ☐ Loss
☐	☐	Chronic sinusitis	☐	☐	Anorexia/Bulimia
☐	☐	Difficulty in swallowing	☐	☐	Blood disorder
☐	☐	Excessive thirst	☐	☐	Tumor, Explain_____________
☐	☐	Diabetes	☐	☐	Cancer, Explain_____________
☐	☐	Headaches	☐	☐	HIV/AIDS
☐	☐	Jaw Pain	☐	☐	Epilepsy
☐	☐	Tinnitus (ear noises)	☐	☐	Fainting
☐	☐	Visual disturbances	☐	☐	Convulsions
☐	☐	Dizziness	☐	☐	Caffeinated drinks: per day____
☐	☐	Bladder infection	☐	☐	Drug or alcohol dependence
☐	☐	Frequent urination	☐	☐	Tobacco, frequency__________
☐	☐	Painful urination	☐	☐	Alcohol, frequency___________
☐	☐	Prostate problems	☐	☐	Birth control pills, type_______
☐	☐	Kidney Stones	☐	☐	Endometriosis
☐	☐	Kidney disorders (by conditions)________	☐	☐	PMS
☐	☐	Loss of bladder control	☐	☐	Breast ☐ Soreness ☐ Lumps
☐	☐	Constipation/irregular bowel	☐	☐	Irregular menstrual flow: Profuse__Light__
☐	☐	Irritable bowel	☐	☐	Number of births
☐	☐	Colitis	☐	☐	Hepatitis

If a family member has had any of the following, please mark the appropriate box:

☐ Cancer	Family member___________	☐ High blood pressure	Family member________
☐ Chronic back problems	Family member___________	☐ Lung problems	Family member________
☐ Chronic headaches	Family member___________	☐ Lupus	Family member________
☐ Diabetes	Family member___________	☐ Rheumatoid arthritis	Family member________
☐ Heart problems	Family member___________		

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

____
Signature Date