

MEDICAL INFORMATION

Name: _____ Age: _____

Primary care physician: _____ Referred by: _____

Describe injury/complain and current symptoms: RIGHT _____ LEFT _____

Date of onset: _____ Attorney involved? YES NO Auto accident? YES NO

What treatment has been given? _____

List all current and past medical problems: _____

List all surgeries and the approximate date: _____

Current medications and dosage:

<u>NAME:</u>	<u>DOSE:</u>	<u>FREQUENCY:</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

If you need additional room, please use reverse side of form.

Are you allergic to any medications YES NO

Name of medication: _____

Reaction: _____

Name of medication: _____

Reaction: _____

Pertinent Family Medical History: (e.g. cancer, heart disease, etc.)

<u>CONDITION:</u>	<u>RELATION:</u>
1. _____	_____
2. _____	_____