General Information

Date: _____

Are you currently working? Y N Brief Job Description: _____

Hours working/week: _____

- If yes, please indicate whether it is regular or modified duty: _____

Past Medical History:

Please check if you have been treated in the past for:

( ) **Heart Problems**	( ) **Joint Dislocation**
( ) **Pacemaker**	( ) **Osteoporosis**
( ) **High Blood Pressure (Hypertension)**	( ) **Ulcers**
( ) **Circulatory Problems**	( ) **Kidney Disease**
( ) **Lung Disease/Problems**	( ) **Any infectious disease (TB, AIDS, Hepatitis)**
( ) **Head Trauma/Concussion**	( ) **Diabetes**
( ) **Migraine Headaches**	( ) **Hernias**
( ) **Epilepsy/Seizures**	( ) **Nervous or emotional problems**
( ) **Cerebrovascular Accident (Stroke)**	( ) **Pregnancy**
( ) **Vertigo/Dizziness/Balance Problems**	( ) **Allergies (latex, medication, food)**
( ) **Cancer**	( ) **Recent accident (fall, motor vehicle accident, etc.)**
( ) **Constant pain unrelieved by rest**	( ) **Arthritis**
( ) **Unexplained weight loss**	( ) **Back or neck injuries**
( ) **Tingling, numbness, or loss of feeling**	( ) **Metal Implant/Joint Replacement**
	( ) **Fracture**

Please provide detail for any of the items checked above: _____

_____

Do you use tobacco? Y N If yes, how much? _____

Please list any current medications: _____

_____

Please list any allergies: _____

Comments: _____

_____