285A Pascack Road

Washington Township, NJ 07676

201-358-9200 (P) 201-358-9201 (F)

 MEDICAL HISTORY

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_ Current Height: \_\_\_\_\_\_\_\_\_\_ Current Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please indicate if you have a personal history of any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Allergies | YES NO | Hepatitis | YES NO |
| Anemia | YES NO | High Cholesterol | YES NO |
| Anxiety | YES NO | High/ Low Blood Pressure | YES NO |
| Arthritis | YES NO | HIV/ AIDS | YES NO |
| Asthma | YES NO | Incontinence | YES NO |
| Autoimmune Disorder | YES NO | Kidney Problems | YES NO |
| Cancer | YES NO | Metal Implants | YES NO |
| Cardiac Conditions | YES NO | MRSA | YES NO |
| Cardiac Pacemaker | YES NO | Multiple Sclerosis | YES NO |
| Chemical Dependency | YES NO | Muscular Disease | YES NO |
| Circulation Problems | YES NO | Osteoporosis | YES NO |
| Depression | YES NO | Parkinson’s Disease | YES NO |
| Diabetes | YES NO | Rheumatoid Arthritis | YES NO |
| Dizzy Spells | YES NO | Seizures/ Epilepsy | YES NO |
| Emphysema/ Bronchitis | YES NO | Smoking  | YES NO |
| Fibromyalgia | YES NO | Speech Problems | YES NO |
| Fractures | YES NO | Strokes  | YES NO |
| Gallbladder Problems | YES NO | Thyroid Disease | YES NO |
| Headaches | YES NO | Tuberculosis | YES NO |
| Hearing Impairments | YES NO | Vision Problems | YES NO |

Have you undergone any of the following testing? (please provide dates)

X-ray \_\_\_\_\_\_\_\_\_\_\_ MRI\_\_\_\_\_\_\_\_\_\_ EMG\_\_\_\_\_\_\_\_\_\_ Cardiac Stress Test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone Density Scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently pregnant? YES NO If Yes, what is your due date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your current level of stress? (circle one) LOW MEDIUM HIGH

Is your current injury the result of a fall? YES NO If yes, how many falls have you

experienced in the past year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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Are you currently taking medications? YES NO

If yes, please list all medications with dosages below.

|  |  |
| --- | --- |
| MEDICATION | DOSAGE |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |
| 6. |  |
| 7. |  |

Have you undergone any surgeries? YES NO

If yes, please list all surgeries with dates below.

|  |  |
| --- | --- |
| SURGICAL PROCEDURE | DATE |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |