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dynamic
Physiotherapy and Chiropractic

Health History Intake Form

Name (print):_____ Date: _____

Please rate and describe you current pain level: (Circle one)

0	1	2	3	4	5	6	7	8	9	10
	None			**Moderate**				**Severe**		

1. Please circle if you have had any of the following:

Diabetes	Circulatory problems	Stroke
Osteoporosis	Lung Disease	Broken bones/fractures
Heart murmur	Epilepsy/seizures	Kidney disease
High Blood Pressure	Cancer	Liver disease
Heart Disease	Arthritis	Neurological problems
Migraines	Other:	

2. Have you had any surgeries? (circle one) YES NO
If yes, please list _____

3. Are you on any medications? (circle one) YES NO
If yes, please list _____

4. Do you have any allergies? (circle one) YES NO
If yes, please list: _____

5. **Females**: Is there a chance you may be pregnant? YES NO

6. What activities are the most difficult due to your current condition?_____

7. Your input is very important in your rehabilitation. Do you have any personal goals or expectations for therapy? (circle one) YES NO
If yes, please explain: _____

9. What previous treatments have you received for your condition? _____

10. What tests have you had for this condition (i.e. x-ray, MRI)? _____

Patient signature: _____