

MEDICAL HISTORY

MARK boxes () that apply. Include CURRENT or PAST problems

- () Implanted Defibrillator () Pregnancy () Active Infection () Active Thrombophlebitis
 - () Epilepsy () Seizure Attack < 1 year ago () History of Severe Burns () Blood Clot < 1 year ago
 - () Implanted neuro-stimulator in the back
 - () ACTIVE Cancer, please describe where: _____
 - () HISTORY of Cancer, please describe where, what year, & the status: _____
 - () Fibromyalgia () Restless Leg Syndrome () Migraines
 - () Diabetes DO YOU TAKE: () Pill () Insulin () Both
- How many years have you been a Diabetic? _____ What is your typical blood sugar reading in a.m.? _____
- () Arthritis Where _____ Circle type: General Rheumatoid Psoriatic Other
 - () History of Blood Clot How many years ago? _____ Where & Why? _____
 - () Heart Attack When _____
 - () Stroke When _____
- | | | |
|--------------------|-----------------|-----------------|
| () Lung | () Anemia | () Cholesterol |
| () Blood Pressure | () Depression | () Hepatitis |
| () Kidney | () HIV or AIDS | () Lupus |
| () Liver | () Thyroid | () Raynaud's |

- HEART PROBLEMS any listed: () Clogged Arteries () Pace Maker () CHF
- () Mitral Valve Prolapse () Rheumatic () Chest pain

List any MEDICAL PROBLEMS not found in the list above _____

If any of the following FAMILY members (Mother, Father, Brother, Sister, Daughter, Son) suffers from the medical problems listed below, please fill in.

Neuropathy _____ Diabetes _____

Arthritis _____ Heart Disease _____

Amputations _____ Cancer _____

List any Current Medications, include vitamins: _____

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List any allergies: _____

List any previous surgeries & the year: _____

Do you smoke: Y N How many packs per day: _____ How many years _____ Do you chew tobacco: Y N

Do you have a history of smoking: Y How many years ago did you stop: _____

Do you drink alcohol: Y N Have you ever been or are you currently an alcoholic: Y N

Do you suffer from any drug dependency: Y N Do you exercise: () Regularly () Never

CIRCLE any current or recent symptoms

Drastic change in WEIGHT

Sore THROAT

Easy BLEEDING

FEVER

Difficulty BREATHING

Pain with URINATION

General FATIGUE

Persistent COUGH

Blood in URINE

Change in SKIN color

Coughing Blood

Frequent Urination

Change in a RASH

CHEST pain

GOITER

Change in a MOLE

CHEST Palpitations

HEADACHES

Blurry VISION

Limb Swelling

Double VISION

Dry EYES

Decrease in APPETITE

BALANCE PROBLEMS

EYE pain

Blood in or Black STOOLS

DEPRESSION

EAR ringing

Nausea or Vomiting

ANXIETY

Dizziness

Easy BRUISING

Slow HEALING

Pain or Stiffness in your: Neck Back Shoulders Wrist Hands Hips Knees

I certify that the information contained on these initial forms are true & correct to the best of my knowledge.

PATIENT'S Signature: _____ Date: _____