DYNAMIC CORE Physical Therapy

MEDICAL HISTORY

Name: _____ **Date:** _____

What treatment have you already received for your condition? ☐ Physical Therapy ☐ Chiropractor
☐ Medication ☐ Surgery ☐ Injection(s) ☐ Other _____

What other doctor(s) have treated you for this condition? _____

What tests have been done to you for this condition?
MRI: _____ X-Ray: _____
EMG / NCV: _____ Other: _____

Place an 'X' in the box to indicate if you have or have had any of the following:

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer
Specify: _____
☐ Concussion
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Fractures
☐ Goiter
☐ Headache
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herniated Disc
☐ HIV / AIDS
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Migraines
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Polio
☐ Prostate Problems
☐ Psychiatric Care
Specify: _____
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
Other: _____

MEDICATIONS	ALLERGIES	VITAMINS / HOLISTIC THERAPY
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you pregnant? ☐Yes ☐No If Yes, due date: _____

Injuries / Surgeries you have had:	Description	Date
Falls:	_____	_____
Broken Bones:	_____	_____
Dislocations:	_____	_____
Surgeries:	_____	_____

EXERCISE	WORK ACTIVITY	HABITS	
☐None	☐Sitting	☐Smoking	Packs/Day _____
☐Moderate	☐Standing	☐Alcohol	Drinks/Wk _____
☐Daily	☐Light Labor	☐Coffee / Caffeine	Cups/Day _____
☐Heavy	☐Heavy Labor	☐High Stress Levels	Reason _____