

MEDICAL HISTORY FORM

MEDICAL HISTORY Is your current condition related to an injury? If YES, was the injury related to: Auto	NIAN 4E.	5.17	г.		
MEDICAL HISTORY Is your current condition related to an injury? If YES, was the injury related to: AutoWorkOtherDate of Injury Have you received physical/speech therapy in the last year? If YES, refer to your insurance policy for limitations. Please check any of the following conditions you have or may have had in the past: Heart Disease Tuberculosis Asthma Heart Murmur	NAME:				
Is your current condition related to an injury? If YES, was the injury related to: Auto Work Other Date of Injury Have you received physical/speech therapy in the last year? If YES, refer to your insurance policy for limitations. Please check any of the following conditions you have or may have had in the past: Heart Disease Currently Pregnant Stroke Heart Murmur Fatique/Energy Loss C.O.P.D. Mood Disorders Chest Pain/Discomfort Hepatitis Shortness of Breath Ankle Swelling Anemia Kidney Disease Epilepsy/Seizures Diabetes Dizzy Spells Allergies Hernia Headaches Cancer: Type Loss of Bladder/Bowel Control Other: ORTHOPEDIC LIMITATIONS Please check any of the following conditions that you have or have had in the past: Osteoporosis Scoliosis Broken Bones Sprains/Strains Arthritis Balance/Walking Problems Fibromyalgia Limited Range of Motion Slipped/Ruptured Disc Subluxed/Dislocated Joints Weakness Painful Grinding/Cracking in a Joint Compression Fractures Have you had a recent: X-Ray MRI CT Scan If so, when? Please list any medications you are currently taking: Please list any medications you are currently taking: Yes No If yes, please list: Signature: Date:		DAI	L OF DIKTH.		
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