THE THERAPY CENTER
EXCEPTIONAL CARE. ESPECIALLY FOR YOU.

PATIENT HISTORY FORM

Name _____ DOB: _____ Sex: M F

Height:_____ Weight:_____ Dominant Hand: R L Occupation: _____

What part of your body would you like us to treat today? _____

How did this injury occur? _____

Did you see a doctor for this injury? If so, who/when? _____

What treatment have you received for this problem? Was it helpful? _____

_____

Did you have any tests done for this issue? If so , when? _____

_____

Have you fallen in the past 12 months? If so how many times? Did this result in any injuries? _____

_____

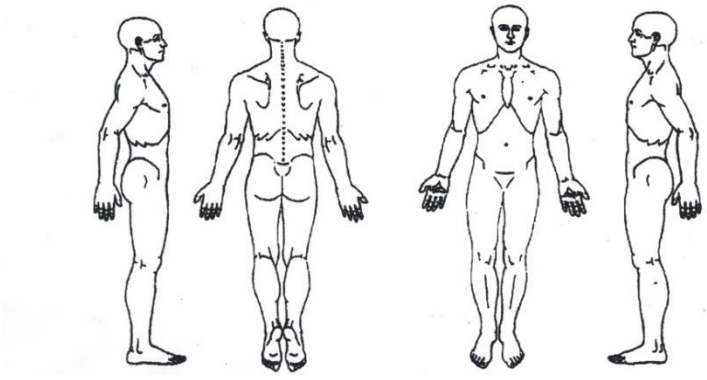
List of Medication

Name of Medication/Supplement	Dosage	Frequency of Use	Route of Administration

Have you ever been diagnosed with any of the following conditions?

Alzheimer's Disease	Y	N	Huntington's Disease	Y	N	Rheumatoid Arthritis	Y	N
Cardiovascular Disease	Y	N	HIV/AIDS	Y	N	Traumatic Brain Injury	Y	N
Cauda Equina Syndrome	Y	N	Other Immune Disorders	Y	N	Concussion	Y	N
Stroke	Y	N	Lupus	Y	N	Night Pain	Y	N
Current Infection	Y	N	Muscular Dystrophy	Y	N	History of Cancer	Y	N
Diabetes	Y	N	Obesity	Y	N	Unexplained Weight Loss	Y	N
Fibromyalgia	Y	N	Osteoarthritis	Y	N	Loss of Bladder/Bowl Control	Y	N
High Blood Pressure	Y	N						

Please mark on the drawing below what areas are affected.



R L