Universal Health & Rehabilitation, PC

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"Your Multidisciplinary Healthcare Solution"

What Services are you Interested in receiving or learning about today? Please circle all that apply.

Chiropractic	**Acupuncture**	**Physiotherapy**
Massage Therapy	**Vestibular Rehabilitation**	**Concussion Therapy**
Pain Management	**Wellness**	**Nutrition**
Exercise Prescription	**Orthotics / Postural Improvements**	

Past Medical - Please Check all that apply

Patient Current Complaints **Check (✓) if you have any of the following:**

- ☐ Dizziness
- ☐ Headaches
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Chest Pain
- ☐ Rib Pain
- ☐ Shoulder Pain
- ☐ Arm/Forearm Pain
- ☐ _____
- ☐ Elbow Pain
- ☐ Wrist/Hand Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Thigh/Leg Pain
- ☐ Ankle/Foot Pain
- ☐ Pins & Needles in Arms
- ☐ Pins & Needles in Legs
- ☐ Numbness
- ☐ Blurred Vision
- ☐ Fatigue
- ☐ Fever/Infection
- ☐
- ☐ Ringing/Pain in Ears
- ☐ Abdominal Pain
- ☐ Urinary/Bowel Incontinence/Difficulty
- ☐ Nausea/Vomiting
- ☐ Loss of Sleep
- ☐ Constant Irritability
- ☐ Loss of Memory
- ☐ Loss of Balance
- ☐ Jaw Pain
- ☐ Depression
- Other: ☐ _____
- ☐

Are you pregnant? ☐ Yes, Due Date: _____ ☐ No

Past Medical History **Check (✓) if you have any of the following:**

- ☐ Anemia
- ☐ Hives or Eczema
- ☐ Chicken Pox/Shingles
- ☐ Glaucoma/Cataracts
- ☐ Pneumonia
- ☐ Hernia/Ulcer
- ☐ Asthma
- ☐ Cancer
- ☐ Venereal Disease
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Pacemaker
- ☐ Any Birth Defects (please list):
- ☐
- ☐
- ☐ _____

- ☐ Tuberculosis
- ☐ AIDS/HIV+
- ☐ High/Low Blood Pressure
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Disc Herniation/Bulge
- ☐ Epilepsy
- ☐ Blood/Plasma Transfusion
- ☐ Headaches
- ☐ Breast Lump
- ☐ Diabetes I/II
- ☐ Brain Disease
- ☐ Infection Mono
- ☐
- ☐

- ☐ Thyroid Disease
- ☐ Bleeding Tendency
- ☐ Hepatitis _____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ History of Tobacco Use
- ☐ History of Alcohol Use
- ☐ History of Drug Abuse
- ☐ Recent Infection/Flu/Dental Work
- ☐
- ☐

Any Other Disease (please list): _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problem/ Stroke ☐ Neurological Disorder

Statement:

To the best of my knowledge. The questions on these forms have been accurately and honestly answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctors office of any changes in my medical status.

_____ _____

Name / Guardian Date