Medical History

Please check all that apply

☐ Is your condition the result of an accident?

☐ employment accident?

☐ auto accident?

☐ other type of accident?

General Health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

☐ Have you had an amputation?

Your activity level: ☐ Low ☐ Medium ☐ Active ☐ Highly Active

Height:_____ Weight:_____ ☐ Recent Changes in weight

Have you had or do you have any of the following?

☐ Heart Problems	☐ Hepatitis A or B	☐ Vision Problems
☐ Hypertension	☐ Hepatitis C	☐ Parkinson's Disease
☐ Vascular disease	☐ HIV Positive	☐ Alzheimer Disease
☐ Stroke	☐ Rheumatoid Arthritis	☐ Psychiatric Problems
☐ Diabetes	☐ Obesity	☐ Alcoholism
☐ Kidney Disease	☐ Osteoarthritis	
☐ Osteoporosis	☐ Pulmonary Disease	☐ TB
☐ Pacemaker/Defibrillator	☐ Currently Pregnant	
☐ Seizer Disorder	☐ MRSA	
☐ Hearing Loss	☐ Known Allergies (including contact materials)_____	

List any other conditions that you feel might affect your treatment (including dates and descriptions of surgeries_____

_____

☐ Currently taking any medications?_____

_____