BALANCE – FITNESS FOR LIFE

PATIENT MEDICAL HISTORY

NAME:____ **REFERRING PHYSICIAN:**____________________
SS#________________________________ **DOB:**_____________________**PH:**______________________________
CELL PH:___________________________**EMAIL:**____
Address:____
Occupation:_____________________Employer:___________________________Work PH:_______________________
Family Physician: _______________________________ Date of First Doctor Visit for this Injury: ____________________
Are You Currently Taking Any Prescription or Non-Prescription Medications? YES NO
List Medications: ____
Are You Allergic to any Medications? YES NO List Medications/known allergens: ____________________________

There are some important questions we need to ask you in order to completely understand your women's health concerns. Answering the following questions will help us to better manage your care.

Are you currently pregnant? Yes ____ Weeks ____ Due Date _______________
No ____ Possibly ____
# of Pregnancies ______ # of Births_______

Births	Delivery Type	Delivery Date	Birth Weight	Pushing Time
1	V C			
2	V C			
3	V C			
4	V C			

Do you now have or Have you ever had ANY of the following?
Please circle if YES

Asthma, Bronchitis, Emphysema
Severe or Frequent Headaches
Shortness of Breath
Chest Pain
Vision or Hearing Difficulties
Coronary Heart Disease or Angina
Numbness or Tingling
Do you have a Pacemaker?
Dizziness or Fainting
High Blood Pressure

Bowel or Bladder Problems
Heart Attack or Surgery
Weakness
Stroke/TIA
Weight Loss/Energy Loss
Congestive Heart Disease
Hernia
Blood Clot/Emboli
Varicose Veins
Epilepsy/Seizures
Allergies
Thyroid Disease or Goiter
Any Pins or Metal Implants
Anemia

Joint Replacement Surgery
Infectious Diseases
Neck/Back Injury/Surgery
Diabetes
Cancer_______________
Chemotherapy/Radiation
Arthritis
Back Injury/Surgery
Osteoporosis
Gout
Sleeping Problems/Difficulties
Emotional/Psychological Problems

Do You use Tobacco?
Bladder/Kidney Infection
Sexually Transmitted Disease
Pelvic Pain
Constipation
Incontinence (urinary/fecal)
Abdominal Pain
Diarrhea
Communicable Diseases
Painful Intercourse
Menopause
Sexual abuse
Other________________

INCONTINENCE QUESTIONAIRE	Always	Sometimes	Never
Do you have trouble making it to the toilet in time?			
Do you have to strain to pass your urine?			
Do you have pain/discomfort when you urinate?			
Do you lose urine during:			
Coughing, Laughing, Sneezing, Lifting			
Sleeping			
Nervousness/Anxiety related situations			
Do you have leakage unrelated to any specific cause?			
Do you have to strain to have a bowel movement?			

- I understand that evaluation and treatment of my diagnosis may involve internal examination and that these are 1:1 sessions. At any time, I am free to bring someone to accompany me during my appointments. **Initials**
- I understand following hands on soft tissue, deep tissue, or dry needling sessions, bruising can occur. If any discomfort or pain occurs it is recommend I call the office. **Initials**__
- Are you aware of your diagnosis & prognosis as explained by your doctor? YES NO
- Based on your awareness, what is your rehabilitation expectations/goals while in this program?
  ____

____
Patient Signature Date