Name: D	ate:
Preferred Pronouns: he/him/his she/her/hers they/	them/their Oother
Who referred you to therapy?	
Have you had any surgeries? O No Yes If yes, date:	
If yes, type:	
Do you have any allergies? ONO Yes If yes, list allergies:	
Past Medical History: Have you ever had any of the following c	onditions? Check all that apply.
○ High blood pressure○ Heart condition○ Stroke	Osteoporosis
O Peripheral Neuropathy O Seizures/epilepsy Vision p	problems O Diabetes
○ Hearing problems ○ Fainting/dizziness ○ Emphy	vsema Cancer
○ Bowel/bladder problems ○ Frequent or severe headaches	○ Arthritis○ Asthma
○ TBI/Concussion ○ Brain injury ○ Spinal Cord Injury	Operession
○ Anxiety○ Panic disorders	
Other:	
Is there any other information regarding your medical history t	
Reason for visit?	
Do you take any medication? Please list (you may use reverse s	side):
Would you like a chaplain to contact you for emotional or spirit	tual support? O No Yes
Would you like a chaplain to contact you for emotional or spirit Signature of Patient or Guardian (if patient is a minor):	tual support? O No Yes
Would you like a chaplain to contact you for emotional or spirit	tual support? O No Yes

If you are experiencing pain related to your reason for visit, please fill out the next page.



MEDICAL HISTORY FORM

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Patient Identification

To help us understand your symptoms, please CIRCLE all that apply.

My pain is worse: in the morning/during the day/at night/constant/with activity/during rest/intermittent

My pain is better: in the morning/during the day/at night/with activity/during rest/intermittent

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best: _____ and at its worst: ____ In the past 7 days: ____

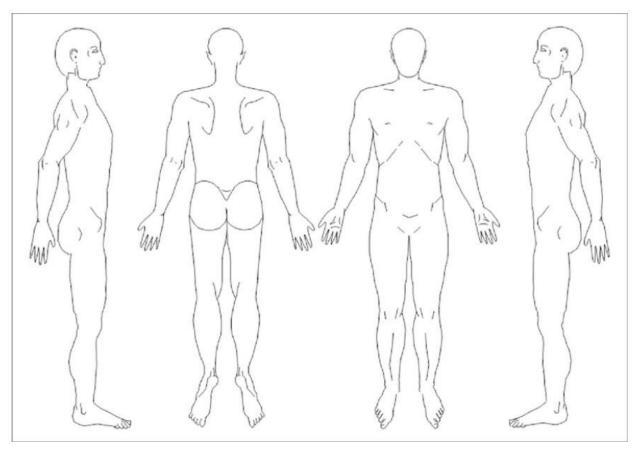
Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition

Key

↑ or ↓ Radiating Pain XXX Spasm ZZZ Tenderness

//// Numbness/Tingling 000 Ache/Pain







MEDICAL HISTORY FORM

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Patient Identification