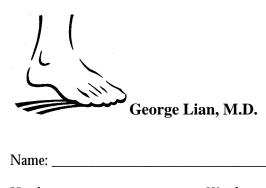
MEDICAL HISTORY



Name:	Birthdate:
Height: Weight:	
Personal Physician:	Referred By:
Describe Current Problem: Right Left	
Were You Injured? Yes No	o If so, When?
How?	
Have you been Treated for This Problem? Yes No By Whom?	
·	l For, e.g. High Blood Pressure, Diabetes, Heart Disease, Arthritis,
Cancer, etc. :	
List any Medications Taken Daily:	
	Much? PPD In the Past?
List any Allergies to Medications, or Other:	
Hospitalizations in Past 3 Years:	
Major Surgeries:	
Other Major Illnesses:	