

**TheraPro
Medical History Form**

(Please Print)

General Information

File #:

Today's Date:

First Name:

Last Name

Date of Birth:

Current Age:

Sex: Male

Female

Medical History

If you have had previous or current experience of the following, please check and describe below:

Surgery Yes No Tuberculosis Yes No

High/Low Blood pressure Yes No Lung Disease Yes No

Heart Attack Yes No Blood Clots Yes No

Pace Maker Yes No Diabetes Yes No

Other Heart Disease Yes No Cancer Yes No

Hepatitis B/C Yes No Osteoporosis Yes No

HIV/AIDS Yes No Pregnancy Yes No

Hyper/ Hypo Thyroid Yes No Neurological Disorder Yes No

Astma Yes No Fractures Yes No

Recent Fever, chills, night sweats, shortness of breath, decreased apatite: Yes No

Explain yes checked: (Surgery Date etc.)

Imaging: (x-rays, MRI CT scan etc. date and result if known)

CURRENT MEDICATIONS

Allergies To:

Current Symptoms

Chief Complaints: (pain, numbness. weakness)

Rate your pain: (please circle) 0 1 2 3 4 5 6 7 8 9 10

Signature:

Date: