PAST MEDICAL HISTORY

DATE OF LAST DOCTOR APPOINTMENT:_____NEXT APPOINTMENT:_____

HAVE YOU EVER HAD THESE SYMPTOMS BEFORE:IF YES, WHEN:_____

CIRCLE WHICH APPLY TO YOUR CURRENT SYMPTOMS:WORK RELATED INJURY--RECURRENCE OF PREVIOUS INJURY--
MOTOR VEHICLE INJURY--CAUSE UNKNOWN--INJURY RELATED TO LIFTING--ATHLETIC/RECREATIONAL INJURY

HAVE YOU HAD RELATED SURGERY:IF SO, WHEN:_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
DIABETES			ALLERGIES TO ASPIRIN		
CHEST PAIN/ANGINA			ALLERGIES TO HEAT		
HIGH BLOOD PRESSURE			ALLERGY/INTOLERANCE TO COLD		
HEART DISEASE			OTHER ALLERGIES		
HEART ATTACK			HERNIA		
HEART PALPITATIONS			SEIZURES		
PACEMAKER			METAL IMPLANTS		
HEADACHES			DIZZINESS/FAINTING		
KIDNEY PROBLEMS			RECENT FRACTURES		
ARE YOU PREGNANT			SURGERIES		
CANCER			SKIN ABNORMALITIES		
BOWEL/BLADDER PROBLEMS			NAUSEA/VOMITING		
ASTHMA/BREATHING DIFFICULTY			RINGING IN YOUR EARS		
LIVER/GALL BLADDER PROBLEMS			RHEUMATOID ARTHRITIS		
SMOKING			SPECIAL DIET GUIDELINES		

BRIEFLY EXPLAIN ANY "YES" RESPONSE_____

_____

_____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS, IF SO WHAT:_____

_____

RATE THE INTENSITY OF YOUR PAIN ON A SCALE OF 1-10)1 BEING NO PAIN, 10 BEING THE WORST POSSIBLE:_____

HIPAA

RIGHT TO REVOKE: YOU WILL HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US WRITTEN NOTICE OF YOUR REVOCATION SUBMITTED TO THE CONTACT PERSON LISTED ABOVE. PLEASE UNDERSSTAND THAT REVOCATION OF THIS CONSENT WILL NOT AFFECT ANY ACTION WE TOOK IN RELIANCE ON CONSENT BEFORE WE RECEIVED YOUR REVOCATION, AND THAT WE MAY DECLINE TO TREAT YOU OR TO CONTINUE TREATING YOU IF YOU REVOKE THIS CONSENT.

PLEASE PRINT NAME

I, _____, HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRIVACY PRACTICES, I UNDERSTAND THAT, BY SIGNING THIS CONSENT FORM, I AM GIVING MY CONSENT TO YOR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS.

SIGNATURE:_____DATE:_____

PERSONAL REPRESENTATIVES NAME:_____RELATIONSHIP TO PATIENT:_____

I GIVE YOU PERMISSION TO SHARE MY PERSONAL INFORMATION WITH THE FOLLOWING PEOPLE:

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____