

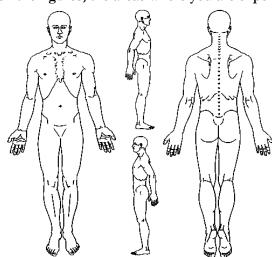
## Medical History and Systems Review

Name			Date			
D.O.B		Age		Female () Male ()		
Has your height or we	eight changed	l in recent months/y	ears?			
Overall Physical Cond	dition: P	oor Fair	Go	od	Excellent	
Occupation		Leisure Acti	ivities			
Do you exercise beyo	nd normal da	ily activities and cho	res? Yes	No		
Describe the reason for	or your visit: _					
Date of Injury/Onset		Onset	(check one):	Gradual	Sudden	
How did the problem	occur?					
Describe the pain:	Dull	Sharp	Constant	Inten	mittent	
•	Sore	Throbbing	Bruised	Burn	ing	
Have you had any sin	AY seeing any Med Oste Den Phys Psyc	of the following? ical Doctor copath	YES YES YES YES YES YES	N N N	IO IO IO IO	
Please list any surgeri Date		hospitalizations and the approximate dates and reasons: Surgery/Hospitalization/Reason				
Please describe any m		•	een treated:			
Date	Inju: ——	ry 				



Date of Last Complete Medical Exam: Physician						
Women Only: Are you pregr	nant? Date of last delivery?	# of Pregnancies				
Please list all PRESCRIPTION medications you are currently taking:						
Have you ever been DIAGN	OSED as having:					
Cancer (Type:)	Fibromyalgia	Digestive Disorders				
High Blood Pressure	Depression/Anxiety	GERD				
Blood clots	Psychiatric Disorders	Ulcers				
Stroke/TIA	Chemical Dependency	Bowel Problems				
Emphysema/C.O.P.D.	Thyroid Problems	Kidney Disease				
Diabetes	Anemia	Urinary/Bladder				
Multiple Sclerosis	Vision/Hearing	Control				
Parkinson's Disease	Infectious Diseases	Epilepsy/Seizures				
Head Injury	Hepatitis	Osteopenia				
Headaches/Migraines	Tuberculosis	Osteoporosis				
Rheumatoid Arthritis	HIV/AIDS	Other				
Osteoarthritis						
Check any CURRENT symp	otoms:					
Chest Pain	Difficulty Walking	Muscle Pain				
Shortness of Breath	Numbness/Tingling	Abdominal Pain				
Heart Palpitations	Weakness	Joint Pain				
Fatigue	Fever/Night Sweats	Other Pain				
Ankle Swelling	Difficulty Sleeping	Limited Movement				
Dizziness	Night Pain					
Coordination Problems	Cough/Hoarseness					
Loss of Balance	Difficulty Swallowing					

Please mark on the figures, the areas where you are experiencing pain.



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