UNIVERSAL THERAPY GROUP

MEDICAL HISTORY FORM

Today's Date_____

Patient Name _____ Occupation _____

Birth Date _____ Age _____

Height_____ Weight_____

List any medication(s) you are allergic to:_____

List any other allergies:_____

Are you latex sensitive? O Yes O No

Have you ever been diagnosed as having any of the following conditions? *(check all that apply)*

O Anemia
O Asthma
O Chemical dependency
O Circulation problems
O Cancer: If yes, what type_____
O Diabetes
O Depression
O Emphysema/Bronchitis
O Epilepsy
O Gastrointestinal disorders
O Heart problems
O Hepatitis: If yes, what type_____
O High blood pressure
O HIV
O Kidney disease
O Multiple sclerosis
O Rheumatoid arthritis
O Other arthritic conditions
O Stroke
O Thyroid problems
O Tuberculosis

Past Medical Problems / Surgeries / Hospitalizations / Injuries

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

FOR WOMEN ONLY:

Are you currently pregnant or think you might be pregnant? O Yes O No
Are you experiencing any gynecological problems? O Yes O No
Is urine leakage a problem for you? O Yes O No

List any PRESCRIPTION MEDICATIONS you are currently taking including pills, injections, and/or skin patches:

_____ _____

_____ _____

_____ _____

_____ _____

List any OVER-THE-COUNTER medications you have taken in the last week:

_____ _____

_____ _____

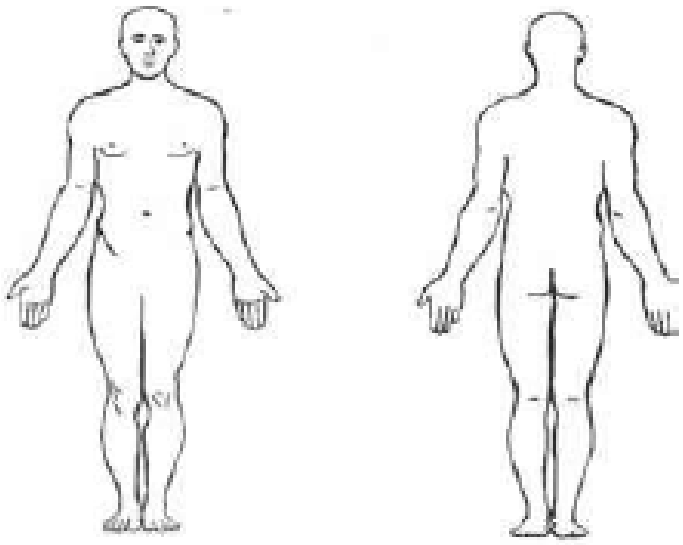
When did problem start for which you are seeking therapy?_____

How did problem start? _____

Test or treatments received for this problem (including therapy) _____

PAIN

Draw your pain:



Rate your pain: (No Pain) 0 . . 1 . . 2 . . 3 . . 4 . . 5 . . 6 . . 7 . . 8 . . 9 . . 10 (Worst Pain)

Describe your pain: *(check all that apply)*

O Dull O Ache O Sharp O Stabbing O Pins & Needles O Shooting Pain O Burning

O Numbness O Tingling O Throbbing O Twinge Other _____

Is your pain constant? . . . . . O Yes O No

Is your pain intermittent? . . . . . O Yes O No

_____ _____

Signature of Patient or Parent/Legal Guardian of Minor Date