Sanders Therapy Group

Medical History

Name: _____ Dominant Hand: Right Left

Are you currently being treated for any other problems other than what brings you here today? YES NO

If YES, please explain: _____

Occupation: _____

FULL TIME PART TIME LIGHT DUTY UNEMPLOYED RETIRED STUDENT DISABLED

Check the following medical conditions that apply TO YOU:

ARTHRITIS	DIABETES	ALLERGIES
HEART PROBLEMS	ALLERGIES TO LOCAL ANESTHETICS	HEADACHES
JOINT REPLACEMENTS	DIFFICULTY SLEEPING	DIZZINESS
HIGH BLOOD PRESSURE	OSTEOPOROSIS	PACEMAKER
CIRCULATORY PROBLEMS	RECENT WEIGHT CHANGE	PREGNANCY
BREATHING PROBLEMS	VISUAL PROBLEMS	NAUSEA
DIFFICULTY WALKING	HEARING PROBLEMS	SEIZURES
HERNIA	DIFFICULTY URINATING	FIBROMYALGIA

HISTORY OF CANCER? IF SO, WHERE? _____

HISTORY OF SURGERY? IF SO, WHERE? _____

Prescription Medication: _____

History of current problem:

When did the problem(s) begin? _____

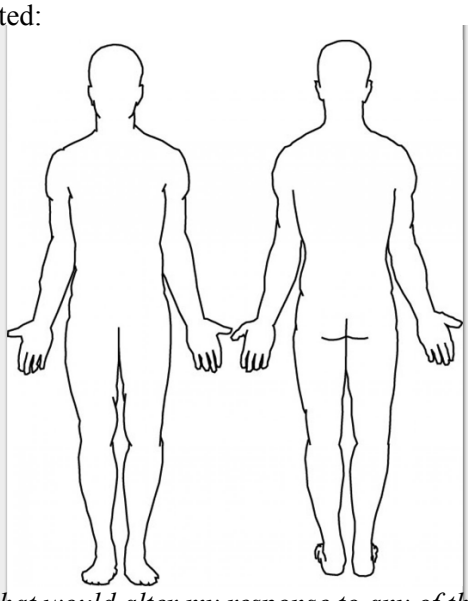
What happened? _____

Have you had the problem(s) before? YES NO

What makes your problem(s) worse? _____

What makes your problem(s) better? _____

Draw on the diagram below exactly where your symptoms (pain, etc) is located:



Please rate your pain based on this scale:

0-No pain
1-Very weak
2-Weak
3-Moderate
4-Somewhat strong
5-Strong
6-
7-Very Strong
8-
9-Very, very strong
10-Emergency

Now: _____

Last 30 days: _____

I will advise the therapist if there are any changes in my physical condition that would alter my response to any of the questions on this form.

Patient: _____ Date: _____