Medical History

Please indicate if your patient had or has a history of any of the following conditions by checking yes or no. Please include relevant information pertaining to the problem.

Patient name_____ **Date**_____

Condition	**No**	**Yes,**	**please explain**
Allergies			
Auditory Impairment			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Speech Impairment			
Visual Impairment			
Diabetes			
Infectious Disease(s)			
Cardiac			
Circulatory			
PVD			
Postural Hypotension			
Hemophilia			
Pulmonary			
Asthma			
COPD			
Neurological			
Seizures/ type Last Seizure / /			
Hydrocephalus			
Shunt			
Sensory Loss			
Pain			
Muscular			
Contractures			
Skeletal			
Spinal Column Injury			
Subluxing Joints			
Dislocating Joints			
Laminetomy/fusion			
Scoliosis – Degree			
Type of brace/Last X-Ray			
Kyphosis/Lordosis Degree/Type			
Spondylolisthesis			
Spinal Abnormality			
Osteoporosis			
Arthritis			
Joint Disease			
Cranial Defects			
Head Injury			
Fractures			