



HANDS ON HEALING

MEDICAL HISTORY

Name: _____ Date: _____

Who is your Primary Care Physician? _____

1. During the past 3 months have you been seen by (check all that apply)?

- Medical Doctor (MD) Chiropractor Physical Therapist Massage Therapist
 Acupuncturist Osteopath (DO) Emergency Room Physician

2. Please list all surgeries and serious illnesses including year:

SURGERIES	YEAR	SERIOUS ILLNESSES	YEAR

3. Have you EVER been diagnosed as having any of the following conditions (Please check all that apply)?

- Cancer Diabetes (sugar) Kidney Disease Heart Attack
 Multiple Sclerosis Epilepsy/Seizures High Blood Pressure Rheumatoid Arthritis
 Anemia Asthma Other Arthritic conditions Fibromyalgia
 Emphysema Depression/Anxiety Osteoporosis/Osteopenia Hepatitis
 Stroke Thyroid Problems Tuberculosis
 Dependence on drugs/alcohol Other (please list) _____

4. Do you presently have any of the following ?

- Productive Cough Night Sweats Weight Loss
 Coughing Up Blood Fever Lethargy/Weakness

5. Please list any broken bones you have had and when:

6. For women: Are you pregnant? Yes No Are you possibly pregnant? Yes No

CURRENT MEDICATIONS

PRESCRIPTION DRUGS FOR	NAME OF DRUG	DOSAGE/FREQUENCY
Pain or inflammation		
Heart condition		
Depression/anxiety		
Blood pressure		
Thyroid condition		
Hormone replacement		
Diabetes		

7. At this time would you say your health is: Excellent Good Fair Poor

8. Occupation: _____

Job Duties: _____

Is your current condition preventing you from working in your regular job? Yes No

If yes, are you working light duty? Yes No Performing a different job? Yes No

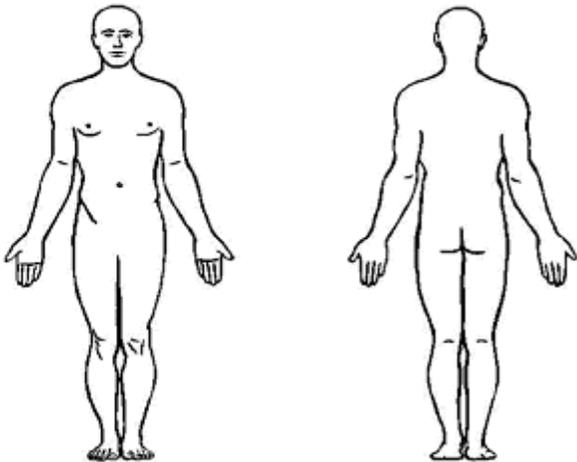
Out of work? Yes No Is your goal to return to your regular job? Yes No

9. Hobbies / Leisure Time Activities: _____

10. What is your primary reason for your appointment with John Leonard, PT, LMBT?

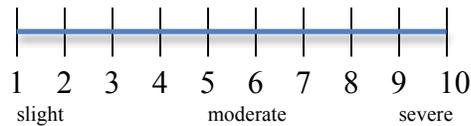
11. How long have you had this current problem(s)?

12. If you are seeing me because of pain, mark the areas of pain by circling or shading the corresponding areas on the figure below:

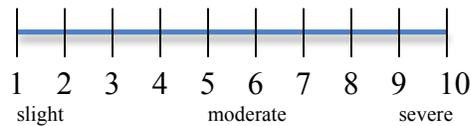


X = Pain O = Numbness

What is your **usual** pain level?



At its **worst** what is your pain level?



At its **best** what is your pain level?

