

Name

Date

## Medical Questionnaire

To help us provide safe and effective treatment, please provide us with the following information (note that all information is treated confidentially)

Do you have a history of		Yes	No	
Diabetes		<input type="radio"/>	<input type="radio"/>	
Heart disease (including blood pressure problems, pacemaker etc.)		<input type="radio"/>	<input type="radio"/>	
<i>if 'yes' please specify:</i>				
Inflammatory arthritis (rheumatoid arthritis)		<input type="radio"/>	<input type="radio"/>	
Cancer		<input type="radio"/>	<input type="radio"/>	
Stroke		<input type="radio"/>	<input type="radio"/>	
Metal implants		<input type="radio"/>	<input type="radio"/>	
Infectious diseases (including hepatitis, HIV/Aids, TB tuberculosis etc.)		<input type="radio"/>	<input type="radio"/>	
<i>if 'yes' please specify:</i>				
Other medical conditions and/or injuries (including allergies, epilepsy etc.)		<input type="radio"/>	<input type="radio"/>	
<i>if 'yes' please specify:</i>				
Other conditions		Yes	No	
Have you been involved in an automobile accident		<input type="radio"/>	<input type="radio"/>	
Have you sustained other injuries that may affect your treatment		<input type="radio"/>	<input type="radio"/>	
Do you have continuous pain while in bed at night		<input type="radio"/>	<input type="radio"/>	
Do you ever suffer from night sweats		<input type="radio"/>	<input type="radio"/>	
Are you pregnant		<input type="radio"/>	<input type="radio"/>	
Have you had a full medical exam within the last year		<input type="radio"/>	<input type="radio"/>	
date:				
Please check any medications you are presently taking and indicate the length of time you have been using them		Yes	No	how long?
Steroids		<input type="radio"/>	<input type="radio"/>	
Prednisone		<input type="radio"/>	<input type="radio"/>	
Muscle relaxants		<input type="radio"/>	<input type="radio"/>	
Antiinflammatories		<input type="radio"/>	<input type="radio"/>	
Anticoagulants (blood thinners)		<input type="radio"/>	<input type="radio"/>	
Blood pressure medication		<input type="radio"/>	<input type="radio"/>	
Insulin		<input type="radio"/>	<input type="radio"/>	
Antidepressants		<input type="radio"/>	<input type="radio"/>	
Other medications		<input type="radio"/>	<input type="radio"/>	
<i>if 'yes' please specify:</i>				
Are you currently involved in		Yes	No	
Regular cardiovascular exercise		<input type="radio"/>	<input type="radio"/>	
Specific fitness / physical activity program		<input type="radio"/>	<input type="radio"/>	
Special dietary practices		<input type="radio"/>	<input type="radio"/>	
Have you suffered from <u>low back</u> pain in the last 6 months?		Yes	No	
<b>If so, during the episode did you ever experience</b>				
Pain radiating into legs		<input type="radio"/>	<input type="radio"/>	
Difficulty controlling the bladder or bowel		<input type="radio"/>	<input type="radio"/>	
Any tingling or numbness in the perinium (genital / anal region)		<input type="radio"/>	<input type="radio"/>	
Increased pain with coughing or sneezing		<input type="radio"/>	<input type="radio"/>	
Have you suffered from <u>neck</u> back pain in the last 6 months?		Yes	No	
<b>If so, during the episode did you ever experience</b>				
Pain radiating into arms		<input type="radio"/>	<input type="radio"/>	
Fainting attacks or blacking out		<input type="radio"/>	<input type="radio"/>	
Periods of dizziness		<input type="radio"/>	<input type="radio"/>	
Feelings of facial numbness or tingling		<input type="radio"/>	<input type="radio"/>	
What is your primary reason for coming in today:				