MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.				
Name: (Last, First, M.I.)		☐ F ☐ M	**DOB:**	
Device Type:		**Visit Type:**	**Visit Date:**	
Device Received within the last five years Y/N		**If yes details:**	**Tobacco Use and Type:**	
Falls in Last 6 months:				
Height:	**Weight:** ☐ **Recent changes in weight?**	**Referring Doctors:**		**Other Doctor:**
☐ **Accident?** ☐ **Your condition is a result of an accident from employment** ☐ **Your condition is a result of an Auto accident** ☐ **Your condition is a result of any other type of accident** ☐ **Amputation?**				
General Health: ☐ **Poor** ☐ **Fair** ☐ **Good** ☐ **Excellent**				
Activity: ☐ **Low (K1)** ☐ **Medium (K2)** ☐ **Active (K3)** ☐ **Highly Active (K4)**				
Do you have any of the following:				
☐ Heart Problems	☐ Hepatitis A or B	☐ Vision Problems	☐ Pacemaker/Defibrillator	
☐ Hypertension	☐ Hepatitis C	☐ Parkinson Disease	☐ Seizure Disorder	
☐ Vascular Disease	☐ HIV Positive	☐ Alzheimer Disease	☐ Hearing Loss	
☐ Stroke	☐ Rheumatoid Arthritis	☐ Psychiatric Problems	☐ Currently Pregnant	
☐ Diabetes	☐ Obesity	☐ Alcoholism	☐ MRSA	
☐ Kidney Disease	☐ Osteoarthritis	☐ Known Allergies (Including contact materials)		
☐ Osteoporosis	☐ Pulmonary Disease (TB)			
List any other conditions that you feel might affect your treatment (including dates and descriptions of surgeries):				
List all injuries related to your visit (sprains, fractures, falls, repetitive stress): When				
Head				
Upper Extremity				
Spine				
Lower Extremity				
Other				
Surgeries:				
Year		**Reason**	**Hospital**	
Currently taking any medications?				

I attest that the information provided above is accurate to the best of my knowledge. I understand that providing incorrect information could result in my being responsible for the cost of services provided.

_____________________________________ _________________________________

Patient Signature: **Date:**