Curative New Berlin Therapies, LLC
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Adult Medical History Form

Patient name: _____ **Today's date:** _____

Chief complaint/concerns: _____

Medications: _____

Diagnostic tests-results (X-ray, MRI, CT scan): _____

Occupation: _____

Primary Care Physician: _____

Referring Physician (if different than Primary): _____

I have pain or difficulty with the following activities: (check all that apply)

_____ getting in & out of chairs
_____ dressing
_____ household chores
_____ driving
_____ work related activities
_____ recreational/sports
_____ going up/down stairs
_____ swallowing
_____ getting in/out of bed
_____ prolonged sitting
_____ sleeping
_____ opening/closing doors
_____ walking in home
_____ walking outside
_____ bathing/self care
_____ speech/communication
_____ getting up/down from floor
_____ lifting
_____ prolonged standing
_____ balance/falls
_____ reaching

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

_____ Heart disease
_____ Stroke
_____ Kidney/Bladder disease
_____ Liver/Gallbladder disease
_____ Obesity
_____ Anemia
_____ Diabetes
_____ Thyroid problems
_____ Reflux disease
_____ Ulcer
_____ Bleeding disorder
_____ Circulatory problems
_____ High blood pressure
_____ Asthma
_____ Emphysema/Bronchitis
_____ Sinus problems
_____ Chemical dependency
_____ Depression
_____ Eating disorder
_____ Hepatitis
_____ AIDS/HIV
_____ Tuberculosis
_____ Autoimmune disease
_____ Gout
_____ Rheumatoid arthritis
_____ Degenerative arthritis
_____ Osteoporosis
_____ Chronic fatigue syndrome
_____ Fibromyalgia
_____ Irritable bowel syndrome
_____ Epilepsy
_____ Headaches
_____ Allergies
_____ Cancer – Describe: _____
_____ Other – Describe/List: _____

Do you have a pacemaker? ☐ Yes ☐ No

Is there a possibility that you may be pregnant? ☐ Yes ☐ No

Do you have any metal implants? ☐ Yes ☐ No

Do you have a Latex allergy? ☐ Yes ☐ No

Please describe any significant injuries, illnesses or operations for which you have required medical attention, and the approximate date of injury/care:

Date	Description
_____	_____
_____	_____
_____	_____
_____	_____

Which of the following OVER-THE-COUNTER products have you used in the last week? (check all that apply)

_____ Aspirin	_____ Laxatives	_____ Antacids
_____ Tylenol	_____ Vitamins/Minerals	_____ Decongestants
_____ Ibuprofen	_____ Tobacco	_____ Antihistamines

_____ Other over-the-counter products, including supplements _____

Do you have a do-not-resuscitate (DNR) Order? ☐ Yes ☐ No

I certify that I have answered this medical history form accurately to the best of my ability. I will not hold Curative New Berlin Therapies responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature Date

(Parent's signature if patient is under 18 years of age or Legal Guardian)

Reviewed by: _____ Date: _____