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PATIENTS PERSONAL HISTORY

Name:_____ Date: _____

1. **HAS THERE BEEN ANY TRAUMA TO THE AREA?** YES OR NO (CIRCLE ONE)

If yes, when and describe:_____

_____

2. **DO YOU HAVE ANY PAIN?** YES OR NO (CIRCLE ONE)

If yes, state the area and describe:_____

_____

PLEASE LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING:_____

_____

PLEASE LIST ANY ALLERGIES THAT YOU MAY HAVE:_____

_____

Are you currently smoking?_____ **If not, history of smoking?**_____

SPINE EXAMS ONLY

1. **DO YOU HAVE ANY WEAKNESS OR NUMBNESS?** YES OR NO (CIRCLE ONE)

If yes, state the area and describe:_____

_____

2. **DOES THE PAIN OR NUMBNESS GO DOWN YOUR ARMS OR LEGS?** YES OR NO (CIRCLE ONE)

FOR WOMEN ONLY:

IS THERE ANY CHANCE THAT YOU MAY BE PREGNANT? YES OR NO (CIRCLE ONE)

DATE OF YOUR LAST MENSTRUAL PERIOD:_____

PATIENT SIGNATURE:_____

Technologist Initials:_____