PATIENT HISTORY

Midland Chiropractic Sports Rehab

Patient Name:

Please list all previous treatments for this condition:

Name of Treating Physician: _____ Dates of Treatment _____

Type of Treatment or Drugs Prescribed: _____

Name of Treating Physician: _____ Dates of Treatment _____

Type of Treatment or Drugs Prescribed: _____

Please list all past surgeries:

Type _____ When _____ Doctor _____

Type _____ When _____

Type _____ When _____ Doctor _____

Type _____ When _____

Please list all previous accidents and falls:

What _____ When _____

What _____ When _____

What _____ When _____

What _____ When _____

Please list any medications or vitamins you arc currently taking:

_____

_____

_____

Please do not write below this line

DOCTORS NOTES :

_____

_____

_____

_____

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_____

_____

PATIENT SIGNATURE _____ DATE _____