Medical History Form

Briefly describe the nature of your injury/condition ________________________________

Date of your injury/ Start of condition __________________

Did you have surgery for this injury ____________________ Date __________________

Rate your pain on a scale of 0-10 (0 = no pain, 10 = worst pain imaginable)

On average ________ At worst ___________

Do you have a history of any major medical conditions? (if yes, please list)

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List any medications you are taking:

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Please add any information that will help your therapist plan your treatment:

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