

PAST MEDICAL HISTORY SUMMARY

Please list any medical problems or injuries that you have had in the last two (2) years including tests, x-rays, medications or treatment received. If you are still experiencing these problems please list the status as "ongoing" and if the problem has been resolved, please list the status as "resolved".

Date	Problem or Injury	Treatment	Current Status

Have you had any surgery? Please describe:

Do you have any upcoming medical test or doctor's appointments? Please describe:

If you are currently receiving any rehabilitation treatment please specify below:

Are you currently wearing any type of adaptive equipment in partial treatment or protection for any existing injury or condition (eg orthotics, brace, helmet, etc.)? Please describe:

Type of treatment (physiotherapy, massage, Chiropractor, Athletic Therapy, etc.)	Name of provider	City and phone number of provider

ALLERGIES

Please list any allergies you may have to:

Medication :

Food :

The environment :

COMMENTS:

Head Injuries/Concussions:

Yes No

1. Have you ever had a head injury?.....

2. Have you ever had a concussion or been "knocked out", "bell rung or been dinged?.....

If yes please list: Number _____

Date(s) Activity at the time Length of unconsciousness Length of time before full return to activity

3. Have you ever had a neck injury? (ie strain, sprain, fracture etc.).....

4. Have you ever had a stinger, burner or pinched nerve?.....