1219 South Main Street
Palmyra, MO 63461
Phone: 573-769-6166
Fax: 573-769-2356

2521 S. Cashua Drive
Florence, SC 29501
Phone: 843-536-4888
Fax: 843-799-0992

Medical History

Patient: ______________________________________ Date: _____________ Ht: ____ft ______ in Weight: _____________

☐ Allergies	☐ Currently Pregnant	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ Anemia	☐ Depression	☐ High/Low Blood Pressure	☐ Seizures
☐ Anxiety	☐ Diabetes	☐ HIV/AIDS	☐ Smoking
☐ Arthritis	☐ Dizzy Spells	☐ Incontinence	☐ Speech Problems
☐ Asthma	☐ Emphysema/Bronchitis	☐ Kidney Problems	☐ Strokes
☐ Autoimmune Disorder	☐ Fibromyalgia	☐ Metal Implants	☐ Thyroid Disease
☐ Cancer	☐ Fractures	☐ MRSA	☐ Tuberculosis
☐ Cardiac Conditions	☐ Gallbladder Problems	☐ Multiple Sclerosis	☐ Vision Problems
☐ Cardiac Pacemaker	☐ Headaches	☐ Muscular Disease	
☐ Chemical Dependency	☐ Hearing Impairment	☐ Osteoporosis	
☐ Circulation Problems	☐ Hepatitis	☐ Parkinsons	

Have you had two or more falls in the last year? YES NO

Is this injury a result of a fall in the past year? YES NO

Under Pain Management YES NO

Surgical History

Surgery: ____ Date: _______________

Surgery: ____ Date: _______________

Surgery: ____ Date: _______________

Current Medications:

Medication:	Dosage:	Frequency:	Route:	Reason for taking:

Pain:

Please rate your pain on a scale of 1-10

(1 is very mild, 5 is moderate, & 10 is very severe):

Current: _____________

Worst (in past 24 hours) ___________

Pain with movement: _____________

Please mark where your pain is located on the chart:

///// is stabbing or sharp

xxx is numbness or tingling

== is burning

vvv is aching

ooo is stiffness or tightness