QUANTUM THERAPY, PC

Medical History

Name:_____ Date:_____

Please fill this out as thoroughly as possible, even if you don't feel it is related to your current problem. It is important to the evaluative process, as well as to avoid any contraindications.

Check next to any medical condition you have, or have had in the past, include a date if applicable. Indicate with a "c" if current or a "p" if in the past.

Major Medical:

___Heart disease
___Cancer
___High/Low blood pressure
___Diabetes
___Stroke/CVA
___Seizure/Epilepsy
___Lung disease
___Peripheral Neuropathy
___Osteoporosis
___Rheumatoid Arthritis
___Fibromyalgia
___Chronic fatigue syndrome
___Osteoarthritis
___IBS/Crohn's
___Hernia
___Aneurysm
___Asthma
___GERD
___Peripheral vascular disease

Pain conditions:

___Headaches/Migraines
___Jaw pain/TMJ
___Low back pain
___Neck pain
___Epicondylitis (tennis elbow)
___Rotator cuff problems
___Sciatica
___Thoracic outlet syndrome
___RSD/CRPS
___carpal tunnel
___Plantar Fasciitis
___Knee pain
___Hip pain
___Piriformis syndrome
___Myofascial Pain Synd.

Uro-Gynecological:

___Pelvic pain
___Coccyx pain
___Pain with intercourse/Dysparuenia
___Incontinence/Frequency
___Cystitis/ Chronic UTI

Women Only:

___Endometriosis
___Fibroids/tumors
___Cystic breasts
___Menstrual problems

Other:

___Difficulty sleeping
___Constipation
___Tinnitus
___Sleep apnea
___Dizziness/Vertigo
___Anxiety
___Depression
___History of sexual abuse
___History of physical abuse
___PTSD

_____

_____

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Medical History (continued)

Surgical History: (includes childhood and oral surgery)

_____
_____
_____
_____
_____
_____

Accidents/Injuries: (car, sporting, major falls, fractures)

_____
_____
_____
_____
_____

Pregnancies/Deliveries:

_____
_____
_____

Medications:	**Purpose:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:

_____
_____
_____

Patient
Signature:_____Date:_____