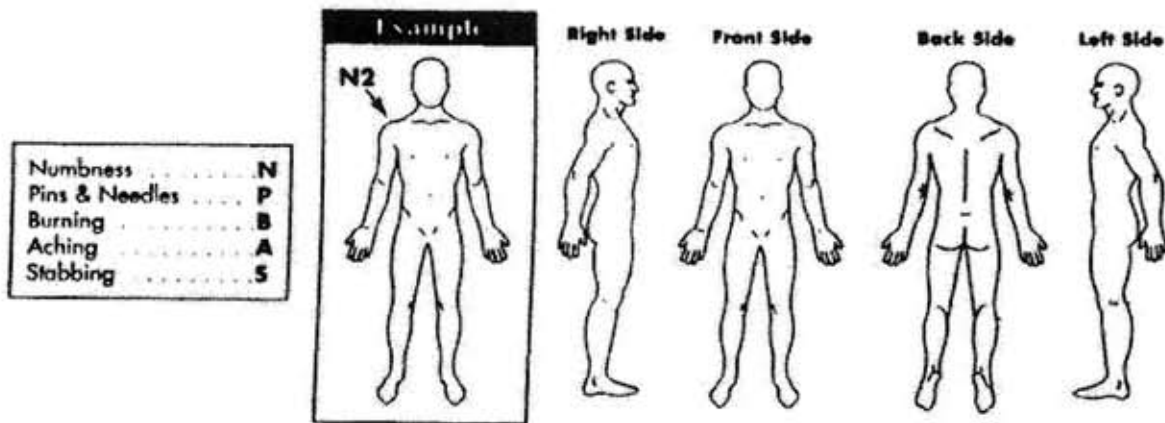




Injuries / Surgeries you have had:	Description:	Date:
Falls: _____	_____	_____
Head Injuries: _____	_____	_____
Broken Bones: _____	_____	_____
Dislocations: _____	_____	_____
Surgeries: _____	_____	_____
Scars: _____	_____	_____

Medications: (prescription & OTC): _____ _____ _____	Allergies: _____ _____ _____	Vitamins / Herbs / Minerals: _____ _____ _____
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Please mark area(s) of injury or discomfort as shown below in the example. Include degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).



I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_  
(Doctor)

Notes:

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