Personal Medical History

Hemberger Structural Integration

Boonton, NJ
550 W Main St
Boonton Township, NJ 07005

Livingston, NJ
3 Royal Ave
Livingston, NJ 07039

Name: _____ Date: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Email: _____

My preferred method of communication/ appointment confirmations is:

_____ Home _____ Work _____ Mobile _____ Email

Date of Birth: _____ Current Age: _____

Occupation: _____

Employer: _____

Primary Care Physician: _____

Referred by: _____

Spouse/Partner: _____

Emergency Contact

Name: _____

Phone: _____

Email: _____

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Please describe the condition you are seeking treatment for, including a brief history and onset:

What are your goals for treatment?

What other treatments have you tried for your pain?

List all diagnostic tests you have had (and results) for your current pain/ condition:

List all past surgeries and approximate dates:

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List all past injuries and approximate dates:

_____

_____

_____

My pain is worse when:

____Sitting ____Standing ____Walking ____Sleeping ____ Moving ____Sedentary

Other things that make my pain worse: _____

Things that make my pain better: _____

List **prescribed** medications that you currently or have recently taken:

Medication	For what condition	Side effects

List **over the counter** medications/supplements that you currently or have recently taken:

Medication/Supplement	For what condition	Side effects

Please list all other medical conditions that you have taken:

_____

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Are you aware of having or have you been diagnosed as having any of the following conditions or symptoms?

Please check and indicate C for current or P for past where appropriate.

Asthma:	Allergies:	Chronic Cough:
Overweight:	Memory loss:	Underweight:
Short leg:	Phlebitis:	Scoliosis:
Sinusitis:	Migraines:	Fibromyalgia:
TMJD:	Herpes:	Dental problems
Chronically cold:	Chronic fatigue:	Diabetes:
Dizziness:	Strength changes:	Tinnitus:
Bloating:	Pelvic pain:	Painful urination:
Painful defecation:	Chronic diarrhea:	Incontinence:
Constipation:	Hypertension:	Arthritis:
Hypotension:	Osteoporosis:	Depression:
Polio:	Alcoholism:	Cancer:
Drug abuse:	Seizures:	Clench/Grind:
Stroke:	Sleep Disorder:	Sleep Apnea:
Autoimmune:	Fainting:	Cardiac Arrhythmia:
Angina:	Thyroid disorder:	Vision changes:
Abdominal pain:	Chronic Prostatitis:	

For women:

Pregnancies:	Ages of children:
Menopause:	Pelvic pain:
Menstrual pain:	

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I smoke _____ cigarettes, cigars, pipes per day.

I drink _____ cups of coffee/tea/caffeinated beverages per day.

I drink _____ alcoholic beverages per day.

I drink _____ glasses of fluid per day.

I chew _____ sticks of gum per day.

Your current height: _____

Your current weight: _____

Left or right handed? ___ Left ___ Right

List your regular exercise routine/frequency:

My goals for exercise are:

I sleep _____ hours per night.

I go to sleep around _____ and wake up at _____.

My sleep quality is: ___ Great ___ Good ___ Poor

I have trouble: ___ Falling asleep ___ Staying asleep ___ Waking up

When I wake up I feel: ___ Well rested ___ Still tired

I sleep on my: ___ Back ___ Stomach ___ Side(s)

I get up to go to the bathroom: ___ time(s) per night

I have: ___ Sleep apnea ___ Insomnia ___ Uncomfortable bed ___ Other (specify)

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Do you where glasses or contacts? ___ Yes ___ No

If yes: ___ Bifocal ___ Progressive ___ Reading ___ Computer

Are you currently working? ___ No ___ Full time ___ Part time

Did you work before your symptoms began? ___ Yes ___ No

Did your pain prevent you from working? ___ Yes ___ No

What are your main activities at work? _____

How long is your commute? _____

I watch ____ hours of TV per day.

I spend ____ hours surfing the web, playing video/computer games per day.

I use the following devices daily:

___ Smartphone ___ iPad/Tablet ___ Laptop ___ Desktop

I use a headset/earpiece when talking on the phone: ___ Yes ___ No

I send approximately ____ texts every day.

Hemberger Structural Integration requires 24 hours notice for any cancellations.

If notification is not given, you will be charged for the treatment session.

Patient Signature: _____ Date: _____