

Medical Background Evaluation Form

Patient Name: _____ Date of Birth: _____

1. Contact & Emergency Information

Phone _____ Email _____

Emergency Contact Name _____ Phone _____

Relationship _____

2. Physician Information

Referring Physician: _____

Primary Care Physician (if different): _____

Date of Last Physician Visit: _____

*Please bring any recent Dr. notes that you would like to share to assist in your care.

3. Medical History

Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease / Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Stroke / TIA	<input type="checkbox"/>	<input type="checkbox"/>	Depression / Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (Type 1 or 2)	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots / DVT	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	COVID-19 (past or current)	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Respiratory Issues	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (RA or OA)	<input type="checkbox"/>	<input type="checkbox"/>

4. Surgical History

Have you had any surgeries or hospitalizations?

No

Yes — If yes, please list below:

Procedure (Date)

Medical Background Evaluation Form

5. Current Medications

Please list all current medications, including prescription, over-the-counter, and supplements:

6. Allergies

Do you have any allergies?

No

Yes — Please list: _____

7. Lifestyle & Functional Status (*prior to injury)

Exercise Frequency: None 1–2x/week 3–5x/week Daily

Description of exercise:

Occupation: _____ Are you currently working? Yes No

Hobbies/Other:

8. Other Clinical Considerations

Symptom	<input type="checkbox"/>	<input type="checkbox"/>	Symptom	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
Unexplained weight loss or gain			Shortness of breath		
Night pain that wakes you			Changes in bowel or bladder habits		
Night sweats			Numbness / Tingling		
Dizziness, fainting, or balance issues			Difficulty swallowing or speaking		
Vision or hearing problems			Are you pregnant?		

9. Acknowledgment and Signature

By signing below, I confirm that the information provided is accurate to the best of my knowledge. I understand that this information will be used to develop an individualized treatment plan.

Patient (or Guardian) Signature: _____

Date: _____