Curative New Berlin Therapies, LLC
2895 S. Moorland Road
New Berlin, WI 53051
262-782-9015

Adult Medical History Form

Patient name: _____ **Today's date:** _____

Chief complaint/concerns: _____

Medications: _____

Diagnostic tests-results (X-ray, MRI, CT scan): _____

Occupation: _____

Primary Care Physician: _____

Referring Physician (if different than Primary): _____

I have pain or difficulty with the following activities: (check all that apply)

☐ getting in & out of chairs	☐ swallowing	☐ bathing/self care
☐ dressing	☐ getting in/out of bed	☐ speech/communication
☐ household chores	☐ prolonged sitting	☐ getting up/down from floor
☐ driving	☐ sleeping	☐ lifting
☐ work related activities	☐ opening/closing doors	☐ prolonged standing
☐ recreational/sports	☐ walking in home	☐ balance/falls
☐ going up/down stairs	☐ walking outside	☐ reaching

Have you EVER been diagnosed as having any of the following conditions? (check all that apply)

☐ Heart disease	☐ Circulatory problems	☐ Autoimmune disease
☐ Stroke	☐ High blood pressure	☐ Gout
☐ Kidney/Bladder disease	☐ Asthma	☐ Rheumatoid arthritis
☐ Liver/Gallbladder disease	☐ Emphysema/Bronchitis	☐ Degenerative arthritis
☐ Obesity	☐ Sinus problems	☐ Osteoporosis
☐ Anemia	☐ Chemical dependency	☐ Chronic fatigue syndrome
☐ Diabetes	☐ Depression	☐ Fibromyalgia
☐ Thyroid problems	☐ Eating disorder	☐ Irritable bowel syndrome
☐ Reflux disease	☐ Hepatitis	☐ Epilepsy
☐ Ulcer	☐ AIDS/HIV	☐ Headaches
☐ Bleeding disorder	☐ Tuberculosis	☐ Allergies

☐ Cancer – Describe: _____

☐ Other – Describe/List: _____

Do you have a pacemaker? ☐ Yes ☐ No

Is there a possibility that you may be pregnant? ☐ Yes ☐ No

Do you have any metal implants? ☐ Yes ☐ No

Do you have a Latex allergy? ☐ Yes ☐ No

Please describe any significant injuries, illnesses or operations for which you have required medical attention, and the approximate date of injury/care:

Date	Description
_____	_____
_____	_____
_____	_____
_____	_____

Which of the following OVER-THE-COUNTER products have you used in the last week? (check all that apply)

____ Aspirin	____ Laxatives	____ Antacids
____ Tylenol	____ Vitamins/Minerals	____ Decongestants
____ Ibuprofen	____ Tobacco	____ Antihistamines

____ Other over-the-counter products, including supplements _____

Allergies: ☐ No/None Known ☐ Yes: _____

Precautions: ☐ No/None Known ☐ Yes: _____

Do you have a do-not-resuscitate (DNR) Order? ☐ Yes ☐ No

I certify that I have answered this medical history form accurately to the best of my ability. I will not hold Curative New Berlin Therapies responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature Date

(Parent's signature if patient is under 18 years of age or Legal Guardian)

Reviewed by: _____ Date: _____