



9. List all the treatments you have had for your current problem (medications, physical therapy, chiropractic, trigger point injections, epidural injections, etc.).

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10. What medical illnesses have you had (**Examples: depression, cancer, arthritis, hepatitis C, heart attack, high blood pressure, high cholesterol, thyroid problems, HIV, etc.**)?

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11. Please list all the medications you take and how often (ex: Motrin 800 mg 3 times/day).

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12. Have you ever used intravenous (IV) drugs (not for medical purposes)?  YES  NO

13. Have you recently lost weight without trying? If so, how much? \_\_\_\_\_ Over what time period? \_\_\_\_\_

14. Associated with your current problem, have you had any high fevers? \_\_\_\_\_ Chills? \_\_\_\_\_ Night sweats? \_\_\_\_\_

15. If you smoke or used to smoke, please list the amount and number of years (example: 2.5 packs per day for 15 years, quit 2 years ago). \_\_\_\_\_

16. How much alcohol do you drink on an average day? \_\_\_\_\_ average week? \_\_\_\_\_ (example 3 cases of beer/week.)

13. List all drugs you are allergic to and the type reaction you have to each. (Example: Codeine makes me itch.)

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14. Please list all the surgeries you have had and the dates of each.

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**Thank you for helping us keep your records accurate.**

X \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Responsible Party Signature