History and Physical Examination

Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

Social Security No: _____ **Sex: Male Female** **I D Verified: ( ) TDL ( ) TID ( ) Other:** _____

Section I: Check all items that apply, **past** or **present** to your health history.

- Under current Medical, Dental, Mental Care, Treatment or Therapy
- Asthma
- Chronic Cough
- Lung Disease
- Tuberculosis
- Heart Disease
- Chest Pain
- High Blood pressure
- Vascular Disease
- Swelling legs & arms
- Varicose Veins
- Allergies
- Diabetes
- Thyroid Disease
- Hospitalization (s)
- Kidney Disease
- Gastrointestinal Ulcers
- Nervous stomach Vomiting, nausea
- Muscular Disease
- Rheumatic Fever
- Hepatitis
- Cancer
- Arthritis
- Sexually Transmitted Diseases
- Missed Periods
- Head or Spine Injury
- Surgery (s)
- Seizures, Fits, Convulsions,
- Disability from Illness, Disease or injury
- Extensive Confinement by Illness or Injury
- Alcohol or Drug Abuse
- Psychiatric Disorder
- Any Nervous Disorder
- Do you take Medication
- Have you been refused a job or forced to give up a job because of health reasons?

Assistive /Corrective Devices

- Glasses • Contacts
- Hearing aids
- Dentures • Retainer
- Artificial limbs
- Joint Replacement ?
- Cane/crutches/walker
- Wheelchair
- Braces • Supports
- Bandages / wraps
- Back /neck braces
- Back Belt / pillow

REMARKS: _____

Section II MEDICAL PROFESSIONAL USE ONLY (Check if normal; Circled if abnormal) N/A = Deferred

General Appearance: Neat Poor Hygiene Behavior: Alert Orientated Non-aggressive Aggressive Confused Dis-orientated

Height	Weight	Blood pressure /
Heart Rate	Temperature	Respirations
Vision Rt.20/ Lt.20/	Pupils Equal Unequal	Hearing Rt. Lt.
Eyes	Ears	Nose
Mouth/Throat	Heart	Pulses
Lungs	Abdomen	Hernia umbilical, inguinal, femoral
Upper Extremity ROM	Lower Extremity ROM	Skin
Neck ROM	Back ROM	DTR's Pupil, Biceps, Triceps, Brach, Patellar, Achilles, Babinski

- No medical restrictions are indicated:
- Accommodations recommended:
- Recommended medical restrictions / limitations:
- Unable to perform essential functions or *"significant risk"* possible:
- Recommend further evaluation / treatment:

Remarks/Comments: _____

_____

_____

_____.
Physician Signature

Joseph H. Lones III, DC
10102 North Lamar Blvd
Austin, TX 78753
(512) 835-1955

_____
Date