POST-OFFER MEDICAL HISTORY QUESTIONNAIRE

Personal Information

Full Name:		Address:	
Date of Birth:	Gender: ☐ Male ☐ Female	Height:	Weight:

Social Security Number:	Position Applied For:	Previous Employer and Position:

Personal Medical History

Condition	Yes	No	Condition	Yes	No
Arthritis	☐ Yes	☐ No	Kidney or Bladder Condition	☐ Yes	☐ No
Asbestosis	☐ Yes	☐ No	Lyme Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Mental Health Condition (including, but not limited to, depression, anxiety, schizophrenia, bi-polar disorder, or other treated condition)	☐ Yes	☐ No
Cancer Condition	☐ Yes	☐ No			
Carpal Tunnel Syndrome	☐ Yes	☐ No			
Cerebral Palsy	☐ Yes	☐ No			
Diabetes (Type I or II)	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Dizziness or Fainting	☐ Yes	☐ No	Muscular Dystrophy	☐ Yes	☐ No
Ear Problems	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Poor Circulation or Vascular Condition	☐ Yes	☐ No
Fractures or Dislocated Bones	☐ Yes	☐ No	Problems with Shoulders	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	Problems with Wrists or Elbows	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Problesm with Knees or Feet	☐ Yes	☐ No
Hepatitis A, B or C	☐ Yes	☐ No	Sciatic Pain or Radiculopathy	☐ Yes	☐ No
Hernia Condition	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
Herniated Discs in Neck or Back	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Ulcer Condition	☐ Yes	☐ No
Hyperinsulinism/Hyperglycemia/ Hypoglycemia	☐ Yes	☐ No	Visual Problems	☐ Yes	☐ No

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Current Treatment and Surgical History

Do you currently experience pain in any part of your body? ☐ Yes ☐ No

If yes, state:

	Location of Pain	**Character of Pain**	**Frequency of Pain**
1.		☐ Sharp ☐ Dull ☐ Throbbing	☐ Occasional ☐ Frequent or Daily
2.		☐ Sharp ☐ Dull ☐ Throbbing	☐ Occasional ☐ Frequent or Daily
3.		☐ Sharp ☐ Dull ☐ Throbbing	☐ Occasional ☐ Frequent or Daily

Have you had any surgery in the past? ☐ Yes ☐ No

If yes, state:

	Operative Procedure	**Approximate Date of Procedure**	**Location of Procedure**
1.			
2.			
3.			

Are you currently treating or taking medication for any medical condition? ☐ Yes ☐ No

If yes, state:

	Nature of Treatment	**Medications**	**Name and Address of Treating Doctor**
1.			
2.			

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3.			

If you are taking medications for any condition, state whether you are restricted from driving or from working? ☐ Yes ☐ No

Are you currently under the care of a physician, psychologist, or psychiatrist for any mental or emotional condition? ☐ Yes ☐ No

If yes, state:

Name and Address of Treating Doctor	**Nature of Condition**

Who is your current primary care practitioner?

Full Name	**Address**

Accident/Claims History

Have you ever been injured in a motor vehicle accident? ☐ Yes ☐ No

If yes, state:

Approximate Date of Accident	**Nature of Medical Treatment**

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Were you ever injured in any work or non-work incident requiring treatment?

If yes, state:

Approximate Date of Incident	**Nature of Injury**	**Did You Lose Time From Work?**	**How Long Were You Unable to Work?**
		☐ Yes ☐ No	

Have you ever filed any claim for benefits for a work-related injury? ☐ Yes ☐ No

If yes, state:

Details of Claim	**Nature of Condition**	**Name of Employer**	**Length of Disability**

Have you ever filed a claim for social security disability? ☐ Yes ☐ No

If yes, state the details regarding the disability claim:

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Have you ever filed a claim for disability from a private disability plan? ☐ Yes ☐ No

If yes, state details regarding disability claim?

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Have you ever been treated by a chiropractor? ☐ Yes ☐ No

If yes, state:

Name and Address of Chiropractor	**Nature Treatment**

Job Accommodations

Will you need reasonable accommodation in order for you to perform the essential functions of the job you have been offered? ☐ Yes ☐ No

If yes, state the details regarding the accommodations you request:

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I CERTIFY THAT THE ABOVE STATEMENTS MADE BY ME ARE TRUE AND CORRECT. I AM AWARE THAT IF ANY OF THE STATEMENTS ARE WILLFULLY FALSE, I MAY BE SUBJECT TO DISCIPLINARY ACTION BY MY EMPLOYER.

EMPLOYEE SIGNATURE	SUPERVISOR'S SIGNATURE AND I.D.	DATE

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