Confidential Health History

Check the following conditions that apply to you, past (within the last 5 years) and present. Please add your comments to clarify the condition.

**Musculo- Skeletal**
- □ Headaches- Frequency: __________
- □ Joint stiffness/ swelling
- □ Spurs/ cramps
- □ Broken/ fractured bones
- □ Strains/ sprains
- □ Back, hip pain
- □ Shoulder, neck, arm, hand pain
- □ Leg, foot pain
- □ Chest, ribs, abdominal pain
- □ Problems walking
- □ Jaw pain/ TMJ
- □ Tendonitis
- □ Bursitis
- □ Arthritis
- □ Osteoporosis
- □ Scoliosis
- □ Bone or joint disease
- □ Other: ____________________________

**Circulatory & Respiratory**
- □ Dizziness
- □ Shortness of breath
- □ Fainting
- □ Cold hands or feet
- □ Cold sweats
- □ Swollen ankles
- □ Varicose veins
- □ Blood clots
- □ Stroke
- □ High Cholesterol
- □ Heart Condition
- □ Allergies
- □ Sinus problems
- □ Asthma
- □ High blood pressure
- □ Low blood pressure
- □ Lymphedema
- □ Other: ____________________________

**Skin**
- □ Rashes
- □ Skin Allergies
- □ Athlete’s Foot
- □ Cosmetic surgeries (List)
  - Type: __________ Date: __________
  - Type: __________ Date: __________
  - Type: __________ Date: __________
  - Other: ____________________________

**Digestive**
- □ Nervous stomach
- □ Indigestion
- □ Constipation
- □ Intestinal gas/ bloating
- □ Diarrhea
- □ Diverticulitis- Onset: ___________
- □ IBS- Onset: ___________
- □ Crohn’s Disease- Onset: ___________
- □ Colitis- Onset: ___________
- □ Other: ____________________________

**Nervous System**
- □ Numbness/ tingling
- □ Face twitches
- □ Fatigue
- □ Chronic Pain
- □ Sleep disorders
- □ Ulcers
- □ Paralysis
- □ Herpes/ Shingles
- □ Cerebral Palsy
- □ Epilepsy
- □ Chronic Fatigue Syndrome
- □ Multiple Sclerosis- Onset: ___________
- □ Parkinson’s Disease- Onset: ___________
- □ Spinal Cord Injury- Onset: ___________
- □ Other: ____________________________

**Reproductive System**
- □ Pregnancy:
  - Current- # Wks: __________
  - Previous- #:________________
  - PMS- □ Mild □ Mod. □ Severe
  - Perimenopause- Onset: ___________
  - Menopause- Onset: ___________
  - Pelvic Inflammatory Disease
  - Endometriosis
  - Hysterectomy- Date: ___________
  - Fertility concerns
  - Prostate problems

**Other**
- □ Drug use: _________________________
- □ Alcohol use: _________________________
- □ Nicotine use: _________________________
- □ Loss of appetite
- □ Hearing impaired
- □ Burning upon urination
- □ Bladder infection
- □ Eating disorder
- □ Diabetes- Onset: ___________
- □ Fibromyalgia- Onset: ___________
- □ Post-Polio Syndrome
- □ Cancer- Type: _________________________
- □ Hyper/Hypothyroidism- Onset: ___________
- □ Hepatitis- Onset: ___________
- □ HIV/ AIDS- Onset: ___________
- □ Other infectious diseases (please list)
  - ____________ Onset: ___________
  - ____________ Onset: ___________
- □ Depression
- □ Other Surgeries (please list)
  - ____________ Date: ___________
  - ____________ Date: ___________
  - ____________ Date: ___________
- □ Other: ____________________________

Please list any additional comments regarding your health: ________________________________________________________________

Please list any area that you would like the therapist to concentrate on: __________________________________________________________

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