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.

Musculoskeletal

☐ Headaches- Frequency: _____
☐ Joint stiffness/ swelling
☐ Spasms/ 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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