Health History Form

For your information:
An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes please let us know. All information gathered for treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ D.O.B.: _____ File #: _____

Occupation: _____ What is your primary complaint? _____

Family Physician: _____ Phone#_____

Health History: Please indicate conditions you are experiencing, or have experienced:

Respiratory
☐ chronic cough
☐ shortness of breath
☐ bronchitis
☐ asthma
☐ emphysema
☐ other: _____

Cardiovascular
☐ high blood pressure or hypertension
☐ low blood pressure
☐ CCHF
☐ heart attack
☐ stroke/CVA
☐ pacemaker or similar device
☐ heart disease
Is there a family history of any of the above
☐Yes ☐ No

Other Conditions
☐ osteoporosis
☐ prolonged steroid use
☐ inflammatory disease
☐ collagen disease
☐ skin conditions, what?
_____

Other Conditions
☐ loss of sensation, where?_____
☐ diabetes (onset: _____)
☐ allergies / hypersensitivity
to what?_____
What kind of reaction?_____
☐ epilepsy
☐ cancer, where?_____
☐ sleeping disorder
☐ arthritis
Is there a family history of arthritis?
☐ Yes ☐ No

Head/Neck
☐ vision problems
☐ vision loss
☐ ear problems
☐ hearing loss
☐ history of headaches
☐ concussion
☐ oral or dental problems or injuries

Infections
☐ hepatitis ☐ HIV / AIDS
☐ TB ☐ Herpes

Women
☐ pregnant (due:_____)
☐ gynecological problems, what?
_____

Soft Tissue/Joint Discomfort and its nature:
☐ neck _____
☐ low back _____
☐ mid back _____
☐ upper back_____
☐ shoulders _____
☐ arms _____
☐ phlebitis / varicose veins _____
☐ legs _____
☐ knees _____
☐ bones _____
☐ other _____

Overall, how is your general health?
_____
_____
_____

Current Medications: _____

Condition it treats: _____

Surgery(s): _____ date(s):_____
nature:_____

Current injury: _____ date: _____
nature:_____

☐ anticoagulants ☐ corticosteroids
☐ methotrexate ☐ cyclosporine A

Are you currently receiving treatment elsewhere?
☐Yes ☐No
If yes, for what? : _____
_____

Other Medical Conditions (e.g. digestive conditions, hemophilia, mental illness, etc.):_____

_____

Of Special Note: (presence of internal pins, wires, artificial joints, special equipment): _____

What is the reason you are seeking therapy? _____

Signature:_____ Date:_____

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