*For your informatio*n:

**Health History Form**

# 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 Other Conditions Women

* chronic cough □ loss of sensation, where? □ pregnant (due: )
* shortness of breath □ diabetes (onset: ) □ gynecological problems, what?
* bronchitis □ allergies / hypersensitivity
* asthma to what?
* emphysema What kind of reaction? **Soft Tissue/Joint Discomfort**
* other: □ epilepsy **and its nature:**
	+ cancer, where? □ neck

**Cardiovascular** □ sleeping disorder □ low back

* high blood pressure or hypertension □ arthritis □ mid back
* low blood pressure Is there a family history of arthritis? □ upper back
* CCHF □ Yes □ No □ shoulders
* heart attack □ arms
* stroke/CVA **Head/Neck** □ phlebitis / varicose veins
* pacemaker or similar device □ vision problems □ legs
* heart disease □ vision loss □ knees

Is there a family history of any of the above □ ear problems □ bones

□Yes □ No □ hearing loss □ other

* + history of headaches

**Other Conditions** □ concussion

* osteoporosis □ oral or dental problems or injuries Overall, how is your general health?
* prolonged steroid use
* inflammatory disease **Infections**
* collagen disease □ hepatitis □ HIV / AIDS
* skin conditions, what? □ TB □ Herpes

**Current Medications**:

* anticoagulants
* methotrexate
* corticosteroids
* cyclosporine A

Condition it treats:

**Are you currently receiving treatment elsewhere?**

**Surgery(s)**: date(s):

nature:

□Yes

□No

If yes, for what? :

**Current injury**: date:

nature:

## 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: