Patient Health History Form

The information requested below will enable us to treat you safely. If you have any questions about the information requested please ask your health care professional (HCP). All information provided below will be kept confidential. Your written permission is required to release any information.

Patient Name: _____

Occupation: _____ **Have you received therapy before?** ❑ **Yes** ❑ **No**

If yes, what were you treated for and when? _____

What is your current reason for seeking therapy? _____

How would you rate your general health status? ☐ Good ☐ Poor ☐ Other _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chronic congestive heart failure
- ❑ Heart attack
- ❑ Phlebitis/ varicose veins
- ❑ Stroke/ CVA
- ❑ Pacemaker or similar device
- ❑ Heart disease

Is there a family history of any of the above conditions? ❑ Yes ☐ No

Respiratory

- ❑ Chronic cough
- ❑ Shortness of breath/ pains
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema

Is there a family history of any of the above conditions? ❑ Yes ☐ No

Do you smoke? ❑ Yes ☐ No

Infections

- ❑ Hepatitis
- ❑ Skin conditions (integrity, wounds)
- ❑ TB
- ❑ HIV
- ❑ Herpes

Other Conditions

- ❑ Cancer (where) _____
- ❑ Diabetes
  Type and onset _____
- ❑ Thyroid disorder
- ❑ Allergies / hypersensitivity to what? _____
- ❑ Epilepsy
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Mental illness
- ❑ Hemophilia
- ❑ Do you have any internal pins, plates, joints?
- ❑ Do you have any artificial limbs?
- ❑ Loss of sensation? Where? _____
- ❑ Nervous system disorder:
  Type: _____
- ❑ Sleep disorders

Is there a family history of any of the above conditions? ☐Yes ☐ No

Head/ Neck

History of Headaches: type & frequency:

- ❑ History of migraines
- ❑ Vision problems
- ❑ Vision loss
- ❑ Ear problems
- ❑ Hearing loss
- ❑ Head trauma

Women

- ❑ Pregnant, due date: _____
- ❑ Gynecological conditions: What? _____
- ❑ Menstrual problems
- ❑ Diseases of the breasts/uterus /ovaries

Digestive

- ❑ Ulcer ❑ Hernia
- ❑ Gall bladder/ liver
- ❑ Kidney / bladder
- ❑ Constipation/ diarrhea
- ❑ Painful/ frequent urination

Do you suffer from any digestive conditions? What are they?

_____

Muscles / Joints

Previous pain / stiffness

- ❑ TMJ
- ❑ Neck
- ❑ Low back
- ❑ Mid back
- ❑ Upper back
- ❑ Hip L/ R
- ❑ Knee L/ R
- ❑ Ankle L/ R
- ❑ Shoulder L / R
- ❑ Elbow L /R
- ❑ Wrist L/ R
- ❑ Hand L/ R
- ❑ Other:

List all medications you are taking and the conditions they are for: _____

_____

List any surgeries you have had. Please include types and dates: _____

_____

List any past injuries. Please include types and dates: _____

_____

Please list any other Health care professional you are currently receiving treatment from: _____

_____

**** If you would like to provide additional information, please turn sheet over and use the blank side.**

_____ _____

For Internal use only
Date of initial health history:
Update 1:
Update 2: