

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? _____

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| <p>Cardiovascular</p> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chronic congestive heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> Phlebitis/ varicose veins <input type="checkbox"/> Stroke/ CVA <input type="checkbox"/> Pacemaker or similar device <input type="checkbox"/> Heart disease <p>Is there a family history of any of the above conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory</p> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Shortness of breath / pains <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <p>Is there a family history of any of the above conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Infections</p> <input type="checkbox"/> Hepatitis <input type="checkbox"/> Skin conditions (acne, athletes foot) <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> Herpes <p>Other Conditions</p> <input type="checkbox"/> Cancer (where) _____ <input type="checkbox"/> Diabetes, type and onset <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Allergies / hypersensitivity to what? _____ <input type="checkbox"/> Epilepsy <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Mental illness <input type="checkbox"/> Hemophilia <input type="checkbox"/> Do you have any internal pins, plates, joints? <input type="checkbox"/> Do you have any artificial limbs? <input type="checkbox"/> Loss of sensation? Where? <input type="checkbox"/> Nervous system disorder: Type: _____ <input type="checkbox"/> Sleep disorders | <p>Head/ Neck</p> <p>History of Headaches: type & frequency: _____</p> <input type="checkbox"/> History of migraines <input type="checkbox"/> Vision problems <input type="checkbox"/> Vision loss <input type="checkbox"/> Ear problems <input type="checkbox"/> Hearing loss <input type="checkbox"/> Head trauma <p>Women</p> <input type="checkbox"/> Pregnant, due date: _____ <input type="checkbox"/> Gynecological conditions: What? _____ <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Diseases of the breasts, <input type="checkbox"/> Uterus or ovaries <p>Digestive</p> <input type="checkbox"/> Ulcer <input type="checkbox"/> Hernia <input type="checkbox"/> Gall bladder/ liver <input type="checkbox"/> Kidney / bladder <input type="checkbox"/> Constipation/ diarrhea <input type="checkbox"/> Painful/ frequent urination <p>Do you suffer from any digestive conditions? What are they? _____</p> | <p>Muscles / Joints</p> <p>Previous pain / stiffness</p> <input type="checkbox"/> TMJ <input type="checkbox"/> Neck <input type="checkbox"/> Low back <input type="checkbox"/> Mid back <input type="checkbox"/> Upper back <input type="checkbox"/> Hip L/ R <input type="checkbox"/> Knee L/ R <input type="checkbox"/> Ankle L/ R <input type="checkbox"/> Shoulder L / R <input type="checkbox"/> Elbow L / R <input type="checkbox"/> Wrist L/ R <input type="checkbox"/> Hand L/ R <input type="checkbox"/> 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.**

Signature

Date

| |
|---|
| <p>For Internal use only</p> <p>Date of initial health history: _____</p> <p>Update 1: _____</p> <p>Update 2: _____</p> <p>Update 3: _____</p> |
|---|