**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any additional comments regarding your health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any area that you would like the therapist to concentrate on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_