

MEDICAL HISTORY- CIRCLE current conditions. Check or mark with an “X” former conditions. EXPLAIN WHERE NECESSARY

My Physician Does Does NOT
 Prohibit me from physical exercise.

MUSCULO-SKELETAL

Headache - Frequency? _____
 Neck/Shoulder/Arm Pain --Circle which one(s)
 Back Pain-(Circle) Low - Mid- Upper
 Hip / Leg Pain (Left / Right / Both)
 Arthritis (Circle) Osteo / Rheumatoid
 Diagnosed by a Dr? YES NO
 Bursitis- Where _____
 Diagnosed by a Dr? YES NO
 Sprains / Strains _____
 Bad / Faulty Posture
 Hernia – Where? _____
 Painful Tailbone (coccyx)
 Stiff Neck--How long _____
 Spinal Curvature (Scoliosis)
 Jaw Pain / TMJ
 Broken Bones / Fractures _____
 Spasms / Cramps - Where _____
 Fibromyalgia – Diagnosed? _____
 Osteopenia – Diagnosed (date) _____
 Osteoporosis - Diagnosed (date) _____
 Other _____

GASTRO-INTESTINAL

Constipation Belching or Gas
 Diverticulitis / Diverticulosis (circle which one)
 Hemorrhoids Irritable Bowel Syndrome
 Colitis Other _____

SKIN

Skin Allergies to _____
 Rashes or Eruptions (Where) _____
 Athletes Foot Warts (where) _____
 Sensitive Skin or Bruise Easily(why) _____
 Other _____

PREGNANCIES

How many _____ How many children _____
 Caesarean Section - How many _____
 Pregnant NOW - What Stage _____
 Other _____

CIRCULATORY

High / Low Blood Pressure (circle)
 Heart Condition Mitral Valve Prolapse
 Varicose Veins (Where) _____
 Blood Clots (Where/When) _____
 Breathing Difficulty
 Rapid/Slow Beating Heart
 Poor Circulation
 Reynaud’s
 Diabetes Kidney Problems
 Other _____

RESPIRATORY

Chronic Cough Asthma
 Chest Pain (explain) _____
 Allergies to _____
 OTHER _____

FEMALE / MALE Specific Problems

PMS Hot Flashes
 Prostate Problems
 Other _____

NERVOUS SYSTEM

Herpes Shingles (when) _____
 Fatigue Sleep Disorders _____
 Numbness / Tingling (where) _____
 Chronic Pain _____
 Eating Disorders _____
 Depression (explain) _____
 Other _____

OTHER Specific Conditions

Cancer / Tumors _____
 Lymph Node(s) Removed – Where _____
 Depression – Are you being treated? _____
 Eating Disorders _____
 Drug / Alcohol Addiction? Treatment? _____
 Other (Explain) _____

INFECTIOUS DISEASES

Tuberculosis (Circle) Active / Inactive
 Aids HIV Positive
 Hepatitis A - B - C - G
 Other _____

ACCIDENTS (Include car or any major accident as well as minor accidents such as sprains/strains that happen often. List approximate dates: _____

SURGERIES (Approx dates) _____

For Internal Use Only - _____ Gave New Client Info _____ Name of Therapist Seeing Client on First Visit

** _____ **
Client Signature or Initial for 2nd Page