

Health History:

Please check the following conditions that apply to you, whether past or present

Musculoskeletal

- Headaches
- Joint stiffness
- Spasms/cramps
- Broken bones
- Sprains
- Back/hip pain
- Ehler-Danlos
- Shoulder/neck pain
- Arm/hand pain
- Leg/foot pain
- Chest/abdominal pain
- Jaw pain/TMJ
- Tendonitis
- Bursitis
- Osteoarthritis
- Rheumatoid arthritis
- Scoliosis
- Bone or joint disease
- Trouble walking
- Osteopenia
- Osteoporosis
- Other

Circulatory and Respiratory

- Dizziness
- Shortness of breath
- COPD
- Fainting
- Cold hands/feet
- Swollen ankles
- Heart failure
- Heart attack
- Sinus issues
- Asthma
- Seasonal allergies
- Lymphedema/Lipedema
- High blood pressure
- Low blood pressure
- Varicose veins
- Blood clots

Skin

- Rashes
- Allergies
- Fungal infection
- Ulcers
- Warts/moles
- Scleroderma
- Acne
- Cosmetic surgery
- Chemical Sensitivity

Digestive

- Nervous stomach
- Loss of appetite
- Hiatal hernia
- Constipation
- Diarrhea
- Fecal incontinence
- Urinary incontinence
- Diverticulitis/IBS
- Crohn's Disease
- Colitis
- Eating disorder
- Ulcers
- UTIs
- Ostomy devices

Reproductive System

- Current pregnancy
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Benign prostate hypertrophy
- Cancers
- Hormone replacement

Nervous system

- Numbness/tingling
- Migraines
- Chronic pain
- Stroke
- Fibromyalgia
- Paralysis
- Epilepsy
- MS/MD/Parkinsons
- Herpes/shingles
- Benign Tremor
- Cerebral Palsy
- Brain/spine injury

Other

- Forgetfulness
- Depression
- Trouble concentrating
- Hearing impaired
- Visually impaired
- Diabetes
- PTSD
- Cancer
- Hepatitis C
- Infectious diseases
- Liver Disease
- Kidney Disease
- Insomnia
- Easy bruising
- Other:
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Please list all prescription and non prescription drugs/supplements, including alcohol/nicotine/THC use:

History of car accidents, falls, concussions, whiplash injuries, serious illnesses:

Date(s)

Incident

In general, how is your health?

What are your major stressors?

Any history of cancers?

Have you had any surgeries?

Date(s)

Surgery

Anything else I need to know?

I have stated all conditions that I am aware of and this information is true and accurate.

Client's initials: _____

Date: _____