HEALTH HISTORY FORM

Name	Today's Date	Date of Birth
Address	City	Postal Code
Occupation	Height	Weight
Phone	Email	

What brings you here?

Any other issues or concerns?

Are you diagnosed with any medical conditions?

Medications and supplements

Please list those you are now taking, explain what they are for and how long you've taken them.

Surgeries

Please list type and date of surgery.

Accidents and injuries including motor vehicle accidents, falls, head injuries, etc.

Please describe.

Which therapies are you presently using?

Please list. For how long?

Systems Review

Please indicate if you experience any of the following.

Neurological

Pain: □headache, □musculoskeletal pain, □numbness, □tingling, □burning, ☐loss of sensation, ☐seizures, ☐worsens with physical, emotional or mental exertion, ☐other:
Sensory and perceptual disturbance: ☐sensory overload, □vision disturbance, ☐motor disturbance, ☐other:
Sleep: □disturbed sleep, □non-refreshing sleep; Quantity_____hrs, quality (1-10)_____ Describe:
Cognition: □difficulty processing information, □difficulty organizing tasks, □difficulty remembering sequences, □information overload, □short term memory loss, □other:

Immune

□recurrent flu-like symptoms that activate/worsen with exertion, □susceptible to frequent infection

Gastrointestional

□abdominal pain, □bloating, □nausea, ☐constipation/diarrhea, ☐Irritable Bowel Syndrome, ☐Crohn's/colitis, ☐food/alcohol/chemical sensitivities (specify)

Genitourinary

☐urinary urgency, ☐frequency, ☐need to pee at night, ☐effort incontinence Describe (How many times/when?):
☐cystitis, ☐kidney stones/infections, ☐prostate problems ☐other:

Gynecological (For women only)

Pregnancy	How many?_____, Children_____, ages of children_____ ☐vaginal delivery, ☐C-section, ☐episiotomy, ☐miscarriage, ☐abortion Any complications? Explain:
Menses	☐PMS, ☐irregular periods, ☐absent periods, ☐hysterectomy, ☐endometriosis, ☐cysts/fibroids
Menopause	☐peri-menopausal, ☐menopausal, ☐post-menopausal

Cardiovascular

☐high blood pressure, ☐low blood pressure, ☐cold hands and feet, ☐inability to tolerate standing, ☐light-headedness, ☐fainting, ☐palpitations, ☐stroke, ☐heart condition, ☐edema, ☐varicose veins ☐other:

Respiratory

☐pneumonia, ☐bronchitis, ☐asthma, ☐sinusitis, ☐difficulty breathing, ☐fatigue of chest wall muscles ☐other:

Skin

☐scars, describe: ☐itching, describe: ☐herpes, shingles

Head

□headache, □tinnitus, □vision loss or changes, □neuralgia, □sinusitis
□other:

Dental

□history of braces, □teeth pulled, □root canal, □bridge, □grind/clench teeth, □night-guard
□other:

Gestation/Birth

As far as you know, did your mother experience any difficulties when she was pregnant with you? Explain:

Were there any complications at your birth? Explain:

Were you adopted?

Any other diagnosed conditions?

Energy level (1-10)_____ Stress level (1-10)_____

Do you experience yourself as sensitive to physical therapy? □yes, □no
If yes: □sensitive, □very sensitive, □extremely sensitive

_____ _____ _____
Name Signature Date