

HEALTH HISTORY (continued)

Please check all that apply:

Head/Neck

- Headaches
Type: _____
- Dizziness/vertigo: _____
- Vision problems
- Sinus
- Hearing problems
- Hearing Loss
- TMJ dysfunction

Women issues

- Menstrual problems
- Pregnant? # of weeks _____
- Children, # _____
- Breast pains, tenderness
- Caesarean section
- Menopause

Men issues

- Prostate
- Testicular cancer

Cardiovascular

- High/Low blood pressure
- Heart attack, date _____
- Stroke, date _____
- Heart disease
Type: _____
- Phlebitis
- Varicose veins
- Poor circulation
- Hemophilia
- Pacemaker

Disclaimer

I hereby certify that I have read and understand all the questions relative to my health and medical history. I have completed all the information accurately and I am aware of no other health conditions not specifically mentioned on the above questionnaire.

Client Signature: _____ Date: _____

Respiratory

- Chronic cough
- Shortness of breath
- Chronic cold
- Smoking, # of years _____
- Asthma
- Emphysema/bronchitis
- Other breathing problems
Types: _____

Skin

- Sensitive skin
- Rashes or sores
- Warts
- Eczema
- Psoriasis
- Loss of sensation
- Other: _____

Muscles & joints

- Swelling
- Stiffness
- Limited movement
- Neck pain
- Back pain
- Arm/wrist pain
- Hip/thigh/leg pain
- TMJ/jaw/tooth pain
- Tendonitis: _____
- Bursitis: _____
- Fractures: _____
- Rheumatoid arthritis
- Osteoarthritis
- Other arthritis _____

Digestive/Urinary

- Acid reflux
- Hernia
- Liver
- Gallbladder
- Kidney
- Diabetes, meds: yes , no
- Constipation
- Diarrhea
- Digestive problems
- Other _____

Other conditions

- Fatigue
- Insomnia
- Depression, grief, anxiety
- Allergies _____
- Epilepsy, meds: yes , no
- Cancer, type: _____
- Immune disorders
(Hep C, TB, HIV)
- Infectious disease
Type: _____

Surgery/Injury (Type & date – including pins/rods/artificial joints)

Other health care

- Regular exercise
- Chiropractor
- Physiotherapy
- Other: _____