HEALTH HISTORY

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M ❑ Non-gendered

Describe briefly your present symptoms:

Please list any other practitioners you have seen for this problem (PT, chiropractor, massage therapy, etc.):

CURRENT COMPLAINTS
Pain: ❑ No ❑ Yes Where?
Numbness or tingling: ❑ No ❑ Yes Where?
Weakness: ❑ No ❑ Yes Where?
Headaches: ❑ No ❑ Yes
Is this problem: ❑ getting better ❑ getting worse ❑ staying about the same
Is your sleep affected?: ❑ No ❑ Yes
Did you have an injury?: ❑ No ❑ Yes When?
How long have you had this problem? ❑ days_____ ❑ weeks_____ ❑ months_____ ❑ years_____

PAST MEDICAL HISTORY		
Do you now or have you ever had:		
❑ Diabetes	❑ Heart murmur	❑ Crohn's disease/IBS
❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ High cholesterol	❑ Pulmonary embolism or DVT	❑ Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Hyperthyroidism	❑ Emphysema	❑ Hepatitis
❑ Cancer (type) _____	❑ Stroke	❑ Stomach or peptic ulcer
❑ Leukemia	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Psoriasis	❑ Cataracts	❑ Tuberculosis
❑ Angina	❑ Kidney disease	❑ HIV/AIDS
❑ Heart problems	❑ Kidney stones	❑ Fibromyalgia
❑ Balance problems	❑ Rheumatoid arthritis	❑ Osteoarthritis
❑ MS	❑ Breathing problems	❑ Ligament sprain
❑ Muscle strain	❑ Broken bone (where)	❑ Joint replacement
❑ Pacemaker	❑ Osteoporosis	
Other medical conditions (please list):		

CURRENT MEDICATIONS		
Drug allergies: ❑ No ❑ Yes To what? Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Drug Name	Dosage (number, strength	How long have you been taking this?

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

MENTAL HEALTH
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Anxiety
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings

OTHER PROBLEMS:

I understand that it is important that my health care practitioner is aware of any health-related issues I might have, and have completed this form to the best of my ability:

Patient Signature:

_____

I have reviewed this patient's health history:

Clinician Signature:

_____