

Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: _____

Circulatory and Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: _____

Skin

- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic surgery
- Other: _____

Digestive

- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive aids
- Other: _____

Nervous System

- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Other: _____

Reproductive System

- Pregnancy:
 - Current
 - Previous
- PMS
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Fertility concerns
- Prostrate problems

Other

- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Drug use _____
- Alcohol use _____
- Nicotine use _____
- Caffeine use _____
- Hearing impaired
- Visually impaired
- Burning upon urination
- Bladder infection
- Eating disorder
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Infectious disease (please list) _____
- Other congenital or acquired disabilities (please list) _____
- Surgeries _____
- Other: _____

For clients who need mobility assistance, please give your height: _____ weight: _____

Please list any additional comments regarding your health and well-being: _____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: _____ Date: _____