

## Health History Form – Page 1

Have you ever had any of the following medical conditions? Please circle yes or no. If yes, please explain.

Allergies or hayfever	Yes	No	
Alcohol/drug abuse	Yes	No	
Anemia	Yes	No	
Arthritis	Yes	No	
Asthma	Yes	No	
Cardiac condition – heart murmur, congenital defect	Yes	No	
Cancer	Yes	No	
Chronic bronchitis or emphysema	Yes	No	
Chest pain or angina	Yes	No	
Depression or psychological concerns	Yes	No	
Diabetes	Yes	No	
Fibromyalgia or chronic pain syndrome	Yes	No	
Guillain-Barre Syndrome	Yes	No	
Gout	Yes	No	
Head injury or concussion	Yes	No	
Heart attack	Yes	No	
Heart surgery or pacemaker	Yes	No	
Hemophilia or other blood disorder	Yes	No	
High blood pressure or hypertension	Yes	No	
HIV positive or AIDS	Yes	No	
Hypoglycemia	Yes	No	
Kidney disease or stones	Yes	No	
Liver disease (Hepatitis, jaundice, cirrhosis)	Yes	No	
Migraine Headaches	Yes	No	
Multiple Sclerosis	Yes	No	
Parkinson’s Disease	Yes	No	
Polio	Yes	No	
Pneumonia	Yes	No	
Rheumatic Fever or Scarlet Fever	Yes	No	
Seizure Disorder or Epilepsy	Yes	No	
Shortness of breath	Yes	No	
Stroke or TIA (transient ischemic attack)	Yes	No	
Thyroid problems	Yes	No	
Tuberculosis	Yes	No	
Ulcers or other stomach problems	Yes	No	
Other (please specify)			

WOMEN ONLY:

ARE YOU PREGNANT? [ ] YES [ ] NO IF YES, HOW FAR ALONG: \_\_\_\_\_

NURSING? [ ] YES [ ] NO

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## Health History Form - Page 2

Reason for this visit: (please circle) work, sports, auto, trauma, or chronic.

Please explain: \_\_\_\_\_  
\_\_\_\_\_

Please describe the pain and its location: \_\_\_\_\_  
\_\_\_\_\_

When did this condition begin: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Is this condition interfering with your (please circle): work, sleep, or daily routine.

If yes, please explain: \_\_\_\_\_

Have you had this or similar conditions in the past:  yes  no

If yes, please explain: \_\_\_\_\_

Have you been seen elsewhere for this condition? \_\_\_\_\_  
\_\_\_\_\_

What x-rays, scans, CTs, or MRIs have you had recently: \_\_\_\_\_

Results: \_\_\_\_\_

Goals for treatment: \_\_\_\_\_  
\_\_\_\_\_

Please list all medications that you are currently taking (prescription, over the counter, and herbal products/supplements): \_\_\_\_\_  
\_\_\_\_\_

List all previous operations/hospitalizations: \_\_\_\_\_  
\_\_\_\_\_

List any past serious accidents with dates: \_\_\_\_\_  
\_\_\_\_\_

Are you wearing:  heel lifts,  sole lifts,  inner soles,  arch supports,  orthotics

What age is your mattress? \_\_\_\_\_ Is it comfortable?  yes  no

Have you had any illnesses in the last 3 weeks (cold, flu, urinary infection)?  yes  no

Do you have a pacemaker, implant, or organ transplant?  yes  no \_\_\_\_\_

Current occupation: \_\_\_\_\_

Does your job involve:  prolonged sitting,  prolonged standing,  
 prolonged walking,  use of small equipment,  use of large equipment,  
 frequent lifting, bending, climbing or turning,  repetitive movement.

*I understand the above information and guarantee this for was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes in my medical status.*

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_