HEALTH HISTORY

The following list of conditions may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems constitute an important component of your health history and assist the doctor with your care or referral for appropriate care.

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Herpes
- ☐ HIV Positive
- ☐ Hypertension
- ☐ Influenza
- ☐ Measles
- ☐ Mental Disorder
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Infection
- ☐ Whooping Cough
- ☐ Other:______________

Please check if you have had any of these symptoms in the past six months

Musculo-Skeletal System:

- ☐ Neck Pain
- ☐ Pain between shoulders
- ☐ Arm Pain
- ☐ Low Back Pain
- ☐ Knee/Leg Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐

Nervous System:

- ☐ Anxiety/Panic Attack
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Pins/Needles
- ☐ Cold Extremities

Male Reproductive System:

- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes

Female Reproductive System:

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Genital Herpes
- ☐ Pregnant: ☐ Yes ☐ No

  Date of last period:____________

Cardio-Vascular System:

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ High/Low Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Other Heart Condition
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling

EENT System:

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ History of Throat Infection
- ☐ History of Ear Infection
- ☐ Tinnitis
- ☐ Hearing Difficulty

Gastro-Intestinal System:

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver/Gall Bladder Dysfunction
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

Genito-Urinary System:

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Odiferous Urination
- ☐ Discolored Urine

General:

- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headache

OCCUPATIONAL INFORMATION

The information provided below will help the doctor evaluate your present condition, and he may offer additional advice based on the information you provide.

Work involves: Bending Stooping Twisting Turning Sitting

Standing: Length of time____________ Lifting: Amount of weight____________

How long do you speak on the phone each day?__________ Traditional receiver Headset

Physical Activity: Sedentary Light manual labor Heavy manual labor

Do you believe that your condition was caused by your work?

Do your work activities aggravate your present condition?

HEALTH/LIFESTYLE HABITS

(Circle the appropriate description(s))

This information will allow the doctor to assess choice that you make in several areas of your life. These choices may, or may not, be contributing to your present condition, but they are an integral part of your overall health.

Sleep: Hours per night _______ Quality: Excellent Good Fair Poor

Do you sleep on your: Back Side Stomach

Do you awaken stiff and loosen as the day goes on? ☐ Yes ☐ No

Do you generally feel refreshed after a quality night of sleep? ☐ Yes ☐ No

Exposures: Do you smoke? Quantity per day: ____________ Number of Years: ____________

Is your home environment smoke filled? ☐Yes ☐No

In your work environment, are you regularly exposed to: smoke ☐Yes ☐No

toxic chemicals ☐ Yes ☐ No

Exercise: Type: __________________________ Frequency: ______________________ Duration: ______________

Type: __________________________ Frequency: ______________________ Duration: ______________

Nutrition: Approximately what percentage of your diet contains fruits and vegetables? 0% 25% 50% 75% 100%

Does your diet contain large quantities of any of the following?

Red Meat Poultry Dairy Refined flour Artificial Sweeteners

Do you drink: Water- ☐ Yes ☐ No Quantity per day __________

Coffee- ☐ Yes ☐ No Quantity per day __________

Soda- ☐ Yes ☐ No Quantity per day __________

Alcohol- ☐ Yes ☐ No Quantity per day __________

Are you currently on any special diet? ☐ Yes ☐ No Please describe: ______________________________

Stress: Do you believe that stress may be affecting your health? ☐ Yes ☐ No

Are you interested to learn if nutrition and/or stress are adversely affecting your health? ☐ Yes ☐ No

I understand and agree that health and accident insurance policies are an arrangement between myself and an insurance carrier. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will immediately be due. All appointments are contractual; notice of cancellation must be made 24 hours in advance. This policy is strictly enforced for massage/bodywork and Tensegrity appointments.

Patient's Signature: ______________________________ **SSN:** __________________ **Date:** ______________

Guardian or Spouse's Signature Authorizing Care: ____ **Date:** ______________