MEDICAL HISTORY

Please indicate which of the following you are currently experiencing, or have experienced in the past by writing (where applicable) **C** (for current) or **P** (for past)

CARDIOVASCULAR
- ❑ Stroke
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Circulatory Disorders
- ❑ Varicose Veins
- ❑ Pacemaker
- ❑ Phlebitis
- ❑ Heart Disease
- ❑ Chronic Congestive Heart Failure
- ❑ Myocardial Infarction

RESPIRATORY
- ❑ Emphysema
- ❑ Asthma
- ❑ Chronic Cough
- ❑ Bronchitis
- ❑ Breathing Difficulty
- ❑ Lung Disorder

NEUROLOGICAL
- ❑ Epilepsy
- ❑ Multiple Sclerosis
- ❑ Loss of Sensation
- ❑ Neuritis
- ❑ Other _____

DIGESTIVE & URINARY
- ❑ Chronic Abdominal Pain
- ❑ Prolonged Constipation
- ❑ Frequent Urination
- ❑ Diarrhea
- ❑ Irritable Bowel Syndrome
- ❑ Ulcerative Colitis
- ❑ Pelvic Inflammatory Disease
- ❑ Gastritis
- ❑ Liver/Gall Bladder
- ❑ Kidney/Bladder

SKIN
- ❑ Easily Bruise
- ❑ Eczema/Psoriasis
- ❑ Rash
- ❑ Cold Sores/Warts
- ❑ Herpes
- ❑ Athletes Foot
- ❑ Loss of Sensation
- ❑ Skin Conditions

_____

_____

HEAD & NECK
- ❑ Headache
- ❑ Migraine
- ❑ Visual Disturbances
- ❑ Earaches
- ❑ Hearing Problems
- ❑ Teeth/Jaw Pain
- ❑ Locked Jaw
- ❑ Sinus Pain
- ❑ Injury
- ❑ Dizziness/ Vertigo

SOFT TISSUE & JOINT Complaints

Left	Right	
❑	❑	Neck
❑	❑	Shoulder
❑	❑	Arm
❑	❑	Chest
❑	❑	Abdomen
❑	❑	Upper Back
❑	❑	Mid Back
❑	❑	Lower Back
❑	❑	Hip
❑	❑	Leg
❑	❑	Knee
❑	❑	Ankle

- ❑ Other_____

FEMALE
- ❑ Menstrual Problems
- ❑ Pregnant: Term _____
- ❑ Menopausal Problems
- ❑ Endometriosis
- ❑ Previous C-Section

MALE
- ❑ Haemorrhoids
- ❑ Prostate Problems
- ❑ Sexual Dysfunction
- ❑ Hernias

OTHER
- ❑ Diabetes
- ❑ Cancer
- ❑ HIV/AIDS
- ❑ Tuberculosis
- ❑ Hepatitis
- ❑ Osteoporosis
- ❑ Arthritis _____
- ❑ Allergies _____

LIFESTYLE CHECKLIST
- ❑ Exercise regularly _____x/week
- ❑ Consume caffeine _____x/week
- ❑ Consume alcohol _____x/week
- ❑ Smoke _____x/week

- ❑ Carpal Tunnel Syndrome
- ❑ Insomnia
- ❑ Fainting
- ❑ Chronic Fatigue Syndrome
- ❑ Seasonal Affective Disorder
- ❑ Fibromyalgia
- ❑ Scoliosis
- ❑ Haemophilia

INJURIES
- ❑ Muscle Strain _____

_____
- ❑ Ligament Sprain _____

_____
- ❑ Fracture _____

_____
- ❑ Whiplash _____

_____
- ❑ Herniated Disc _____

_____
- ❑ Other: _____

SURGICAL IMPLANTS
Pins, plates, wires, artificial joints:

_____

_____

_____

_____

Other:

_____

_____

_____

_____

I, _____, have completed this form to the best of my knowledge. I will notify my therapist if my health changes at any time, including diagnoses and other treatments I am undergoing (including medications).
I understand there is a risk to any treatment received, and my therapist will answer any and all questions I have relating to my treatment. I recognize my right to change, modify or stop my treatment at any time.

Date:_____ Signature:_____

Record Updated:

_____

_____

_____