<u>Health History Information</u>

All information retained on this form will be kept strictly confidential and will be used only for treatment planning

Name:________________________________ Date of Birth:______________________
Home Phone:__________________________ Work Phone:_______________________
Address:______________________________ Postal Code:_______________________
E-mail address:________________________ Referred By:_______________________
Weight:________ Occupation/ duties:____
Physical Activities:____
Doctor's name and address:____

Please circle any of the following that apply to you:

HEADACHES/MIGRAINES	HEPATITIS	STRESS
EAR/EYE PROBLEM	SKIN CONDITIONS	INSOMNIA
	TB	
CHRONIC COUGH	HIV	CANCER
SMOKING	HERPES	EPILEPSY
ASTHMA/EMPHYSEMA	PLANTAR WARTS	
HIGH/LOW BLOOD PRESSURE	STOMACH	ARTHRITIS /
HEART DISEASE	CONSTIPATION	FAMILY HISTORY
PHLEBITIS/VARICOSE VEINS	LIVER	OF ARTHRITIS
STROKE	KIDNEY	
DIABETES	BLADDER	

Pregnant: Due date:________________ # of children:____________________________
Menstrual problems:________________ Menopausal problems:_____________________

Circle areas of concern:	NECK	UPPER ARM/FOREARM/HANDS
SCALP	SHOULDERS	UPPER LEG/LOWER LEG/FEET
ABDOMEN/GLUTES	UPPER BACK	**Joints**:
PECTORIALS	MID-BACK	HIPS/KNEES/ANKLES
BREASTS	LOW BACK	SHOULDER/ELBOW/WRISTS

Description of concern:____
____

Surgery – date:_____________________ Current symptoms:_______________________
Injury – date:______________________ Current symptoms:_______________________
Medications:____

I understand that this time has been reserved for me and 24 hours notice is required for cancellation of subsequent visits.

I give my consent to treatment.

Signature:________________________________ Date:_____________________________