HEALTH HISTORY: Please indicate conditions you are experiencing, or have experienced in the past:

Please include all information whether you feel it's relevant or not – Remember our muscles hold memories!

General
- ❑ Allergies

Describe:_____
- ❑ Cancer – Type:_____
- ❑ Diabetes – Type:_____
- ❑ Epilepsy – Type:_____
- ❑ Fainting / Dizziness
- ❑ Fatigue / Loss of Sleep
- ❑ Fever / Sweats
- ❑ Numbness/Tingling/ Loss of Sensation

Respiratory
- ❑ Chronic Cough
- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Bronchitis / Pneumonia
- ❑ Asthma
- ❑ Emphysema
- ❑ Smoking: #yrs:_____

Genitourinary
- ❑ Frequent / Painful Urination
- ❑ Kidney / Bladder Infection
- ❑ Urinary Tract Infection
- ❑ Kidney Stones
- ❑ Prostrate Trouble
- ❑ Incontinence

Bone / Arthritis
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Osteoporosis / Osteopenia
- ❑ Gout

Head/Neck
- ❑ Failing Vision
- ❑ Deafness / Hearing Loss / Tinnitus
- ❑ Ear Ache / Ear Discharge
- ❑ Nose Bleeds – Freq._____
- ❑ Nasal Obstruction
- ❑ Sore Throat
- ❑ Gum Trouble / Bleeding
- ❑ Frequent Colds
- ❑ Tonsillitis
- ❑ Sinusitis
- ❑ Jaw Pain / TMJ Dysfunction
- ❑ Headaches / Migraines

Describe:_____

Frequency: Weekly/ Occasionally/ Stress

Skin
- ❑ Eczema/Psoriasis Loc:_____
- ❑ Itchy/ Dry Skin / Rash

Location:_____
- ❑ Bruises Easily
- ❑ Sensitive Skin
- ❑ Warts

Location:_____

Infectious Diseases
- ❑ Chicken Pox – When:_____
- ❑ Mumps / Measles
- ❑ Hepatitis A B C
- ❑ TB
- ❑ HIV
- ❑ Infectious Skin Condition

Type:_____
- ❑ Other: _____

Women
- ❑ Pregnant Due Date_____)
- ❑ # of Pregnancy: _____)

Type of Child Birth?_____
- ❑ Miscarriage(s)_____
- ❑ Menstrual Pain
- ❑ Irregular Cycle / Excessive Flow
- ❑ Cramps and or Backache
- ❑ Breast Tenderness / Swelling
- ❑ Lumps in Breasts
- ❑ Menopause / PMS
- ❑ Yeast Infections
- ❑ Fibroids / Cysts

Cardiovascular
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chronic Congested Heart Failure
- ❑ Heart Attack / Angina
- ❑ Varicose Veins Loc:_____
- ❑ Phlebitis
- ❑ Stroke/CVA
- ❑ Poor Circulation
- ❑ Swelling In Ankles

Gastrointestinal
- ❑ Poor / Large Appetite
- ❑ Difficult Digestion
- ❑ Excessive Belching or Gas
- ❑ Constipation / Diarrhea / IBS
- ❑ Liver / Gallbladder Trouble
- ❑ Acid Reflux / Hiatus Hernia
- ❑ Stomach Pain
- ❑ Hemorrhoids

Present/Past Involvement in Therapies:

❑❑ Massage ❑❑ Chiropractic ❑❑ Physiotherapy ❑❑ Naturopathy ❑❑ Acupuncture ❑❑ Osteopathy ❑❑ Other

_____

Injury: _____ **Date:** _____ **Surgery:** _____ **Date:** _____

Nature: _____ **Nature:** _____

Injury: _____ **Date:** _____ **Surgery:** _____ **Date:** _____

Nature: _____ **Nature:** _____

Other Medical Conditions: (digestive or gynecological conditions, hemophilia. hypophilia, anemia, fibromyalgia, SLE)

_____

Of Special Note: (presence of internal pins, wires, artificial joints, pacemaker/similar device, or special equipment):

_____

Updated _____ Updated _____ Updated _____ Updated _____

THANK-YOU for taking the time to complete this health profile. Please ask your therapist if you have any questions.