EXISTING OR PAST CONDITIONS AND/OR TREATMENTS

HEAD/NECK
( ) headache
( ) migraine ( ) with aura
( ) vision problems
( ) contact lenses
( ) earache
( ) hearing problems

RESPIRATORY
( ) asthma
( ) chronic cough
( ) shortness of breath
( ) bronchitis
( ) emphysema

INFECTIOUS CONDITIONS
TB ( ) yes ( ) no
HIV ( ) yes ( ) no
Hepatitis ( ) yes ( ) no
type _______________
Infectious skin condition(s)
( ) yes ( ) no
location_______________

SKIN
( ) skin conditions
type: ___________
( ) bruise easily
other: ___________
loss of sensation?___
where? ___________

DIGESTIVE/URINARY
( ) difficult digestion
( ) constipation
( ) liver/galbladder
( ) kidney/bladder
( ) diabetes, onset _______
type: ___________________

MUSCLES/JOINTS

	Current	Previous
Neck	( )	( )
Low-Back	( )	( )
Mid-Back	( )	( )
Upper Back	( )	( )
Shoulders	( )	( )
Hip	( )	( )
Knee	( )	( )
Ankle	( )	( )
Other		
__________	( )	( )

CARDIOVASCULAR
( ) high blood pressure
( ) low blood pressure
( ) poor circulation (Dr. diagnosed?__)
( ) heart disease
( ) shortness of breath
( ) phlebitis
( ) varicose veins (Dr. diagnosed?___)
( ) chronic congestive heart failure
( ) stroke
( ) myocardial infarction
( ) pacemaker

OTHER CONDITIONS
( ) hemophiliac
( ) epilepsy
( ) allergies
list specific ___________
( ) frequent colds
( ) cancer-location________
date of last check-up _______
( ) arthritis ( ) OA ( ) RA
other:____________________
Dr. diagnosed? ____________
affected areas _____________

FEMALE
( ) menstrual problems
( ) painful_heavy_scant
( ) pregnancy
due date:____________
( ) menopausal problems
type:________________

SPECIAL NOTE
( ) pins
( ) wires
( ) artificial joints/limbs
( ) other ____________

CURRENT MEDICATIONS
1. Name:______________________
condition:_____________________
2. Name:______________________
condition:_____________________
3. Name:______________________
condition:_____________________

BLOOD PRESSURE
(to be taken by therapist)
____
Date:______________
Time:______________

OTHER HEALTHCARE PRACTIONERS	Date Began	Reason For Treatment
( ) Chiropractic	___________	___________________
( ) Physiotherapy	___________	___________________
( ) Massage Therapy	___________	___________________
( ) Other	___________	___________________

( ) Special Needs:____

PREVIOUS INJURIES/SURGERIES
1. type____________date____________
explain____________________________

2. type____________ date____________
explain_____________________________

3. type____________ date____________
explain____________________________

4. type____________ date____________
explain____________________________