Health History

Check the following conditions that apply to you, past and present. Please add your comments to the condition.

Skeletal

- ☐ Headaches
- ☐ Stiffness/swelling
- ☐ PMS/cramps
- ☐ Sprains
- ☐ Back, hip, pain
- ☐ Shoulder, neck, arm, hand pain
- ☐ Foot pain
- ☐ Ribs, abdominal pain
- ☐ Problems walking
- ☐ Jaw pain, TMJ
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Joint disease
- ☐ Other:_____

Respiratory

- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Swollen ankles
- ☐ Pressure sores
- ☐ Varicose veins
- ☐ Blood cots
- ☐ Heart condition
- ☐ Allergies
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymph edema
- ☐ Other:_____

Skin

- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's foot
- ☐ Warts
- ☐ Moles
- ☐ Acne
- ☐ Cosmetic surgery
- ☐ Other:_____

Digestive

- ☐ Nervous stomach
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas/bloating
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Adaptive aids
- ☐ Other: _____

Nervous System

- ☐ Numbness/tingling
- ☐ Twitching of face

List any additional comments regarding your health and well-being: _____

_____

I have stated all conditions I am aware of and this information is true and accurate. I will inform the health provider of any changes in my status.

Signature: _____ Date: _____

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