

HEALTH HISTORY

Patient Name:	Date:
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In order to provide the best care possible, please complete this form. All information will remain confidential.

1. Do you have High Blood Pressure (Hypertension)?	NO	YES
2. Do you have Diabetes?	NO	YES
3. Do you have Epilepsy?	NO	YES
4. Do you have Asthma or other Respiratory Conditions?	NO	YES
If yes, please specify:		
5. Do you have history of Heart Disease (Chest Pain)?	NO	YES
If yes, please specify:		
6. Do you have Allergies or Sensitivities to drugs, tape, creams, hot or cold?	NO	YES
If yes, please specify:		
7. Do you have any metal implants (i.e. pins, plates, screws, hip/knee replacement)?	NO	YES
If yes, please specify:		
8. Are you pregnant?	NO	YES
9. Have you had recent X-Rays?	NO	YES
If yes, please specify:		
10. Are you taking any medications?	NO	YES
If yes, please specify and/or include a list:		
11. Have you had any major surgery, tumors, or serious illnesses?	NO	YES
If yes, please specify:		
12. Are you receiving any treatment at the present (i.e. Chiropractic, Radiation, Chemotherapy)	NO	YES
If yes, please specify:		
13. Have you had similar treatments?	NO	YES
If yes, please specify:		
14. Are you physically active?	NO	YES
If yes, please specify:		
15. Is there anything else we should be aware of?		

Emergency Contact Information:

Name	Relationship:	Phone#: () -
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Signature _____ Date: / /