

APPLICANT HEALTH HISTORY

Today's Date: _____ Applicant's Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Age: _____ Date of Birth: _____

Have you received a professional. Massage or any other form of body work? ____Yes____No
If so, what type(s)?

Please list the health practitioners (medical, mental health, physical therapy, acupuncture, chiropractic, etc.) currently treating you:

Practitioner's Name	Type of Treatment	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____

What are your current goals, in seeking care? _____

What joint problems, surgeries, injuries or mental or physical illnesses to you or have you had? How do these affect you currently?

Please list any medications you are taking, and the condition(s) they are prescribed to treat.

Do they control the condition(s)? _____

What side effects, if any, do you experience? _____

Do you use recreational drugs? ____Yes____No

Do you smoke? ____Yes____No

Do you use alcohol? ____Yes____No If so, how often? _____

Do you have allergies? ____Yes____No If so, to what? _____

Are you pregnant? ____Yes____No

Do you wear contact lens? ____Yes____No

What kinds of exercise to you do regularly? _____

Please mark any of the conditions listed below that you currently have or have had in the past, and indicate the dates in the space to the right.

Systemic Infections: Mononucleosis_____ T.B._____ Flu_____ Hepatitis_____ Fever_____ Other_____

Cardiovascular: Heart Attack_____ Heart Disease_____ High/Low Blood Pressure_____ Varicose Veins_____ Phlebitis_____ Stroke_____ Blood Clots_____ Acute Inflammation_____ Other_____

Musculoskeletal: Whiplash_____ Back Pain_____ Sprain_____ Fracture_____ Foot Pain_____ Scoliosis_____ Osteoporosis_____ Rheumatoid Arthritis_____ Osteoarthritis_____ Sports Injuries_____ Torn Ligaments/Cartilage/Tendons_____ Other_____

Neurological: Sciatica_____ Headaches_____ Slipped Disk_____ Multiple Sclerosis_____ Tingling/Numbness/Weakness/coldness in Limbs_____ Other_____

Skin Scabies_____ Lice_____ Herpes I_____ Herpes II_____ Eczema_____ Burns_____ Other_____

Infections: Ringworm_____ Athlete's Foot_____ Warts_____ Other_____

Endocrine: Diabetes_____ Hypoglycemia_____ Other_____

Respiratory: Emphysema_____ Hay Fever_____ Asthma_____ Sinusitis_____ Pneumonia_____ Pleurisy_____ Other_____

Reproductive: Menstrual Cramps_____ PMS_____ Prostatitis_____ Endometriosis_____ Other_____

Urinary: Urinary Tract Infections_____ Frequent Urination_____ Difficult or Painful Urination_____ Other_____

Psychological: Mood Swings_____ Sleep Disorders_____ Exhaustion_____ Depression_____ Acute Anxiety_____ Other_____

Cancer: Please Describe:_____ Dates:_____

Surgery: Please Describe:_____ Dates:_____

Miscellaneous: Please Describe:_____ Dates:_____

I affirm that the above information is true, accurate and current to the best of my knowledge.

Applicant Signature

Date