Health History Questionaire

Date:

Name:_____	Home #_____
Address:_____	Cell Phone #_____
_____	Email Address:_____
Date of Birth:_____ Age:_____	Male/Female / Are you pregnant? Y/N
Occupation:_____	Do you smoke? Y/N
Main Complaint:_____	
_____	
Describe symptoms:_____	When did symptoms begin?_____
_____	Are you presently in treatment?_____
What medication are you taking? _____	What other types of Bodywork have you received?
_____	_____
What surgeries have you had?_____	_____

Medical History: Briefly explain any conditions you have experienced.

skin problems: (dryness, pimples)		night sweats	
respiration problems		emotional problems	
asthma		anxiety	
shortness of breath		poor memory	
frequent colds			
cough		lack of will	
stuffy nose		low back ache	
allergies		lower body edema	
scratchy throat		premature graying	
poor sense of smell		balding	
bloody nose		sterility	
afternoon fever/daytime sweating		infertility	
hot palms/soles of feet		impotence	
insomnia		teeth/gum problems	
		incontinence	
poor appetite		blood in urine	
abdominal distention		difficulty urinating	
loose stools		osteoporosis	
poor digestion		ear problems:	
lack of energy		tinnitus	
nausea		hearing loss	
vomiting		brittle bones	
diarrhea		broken bones	
constipation			
hiccups		abnormal menses	
easy bruising		PMS	
weak limbs		sore muscles/tendons	
hemorrhoids		stiffness	
over worrying		spasms	
varicose veins		muscle cramps	
poor concentration		depression	
		nail problems	
palpitations		eye problems/ glasses?	
tightness in chest		nightmares	
speech problems		migraines	
tongue ulcers		high blood pressure	
cold hands		tender breasts	
abnormal sweating		breast lumps	
Any history of cancer, explain			
Diabetes			

Childhood Medical History:_____

Parents Medical History:_____