Health History & Assessment

Patient Name_____ **Date:** _____

Exercise: 0 1 2 3 4 5 6 7 days/ wk _____minutes. Type_____
What position do you sleep in: Side Stomach Back Other_____
How old is your mattress: _____ yrs What type: coil spring foam water air _____
What type of pillow do you sleep on: foam memory foam fiberfill feather Other_____
Do you wear: arch supports orthotics heel lifts
Do you take: blood thinners (heparin, coumadin, warfarin), birth control pills, steroids
Do you have any **family** history of: rheumatoid arthritis, gout, ankylosing spondylitis, lupus, stroke

Please indicate if you have experienced any of the following conditions or symptoms:

General

- ❑ Cancer
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ AIDS or HIV
- ❑ Fatigue
- ❑ Recent unexplained weight loss,
- ❑ Decreased energy
- ❑ Loss of appetite
- ❑ Night sweats
- ❑ Fever or chills
- ❑ Recurrent infections
- ❑ Fluoroquinolone antibiotic use
- ❑ Skin ulcers or rashes
- ❑ Excessive thirst

Neuromusculoskeletal

- ❑ Stroke
- ❑ Paralysis
- ❑ Seizures
- ❑ Mental disorders
- ❑ Fractures
- ❑ Dislocations
- ❑ Orthopedic problems
- ❑ Arthritis
- ❑ Rheumatoid arthritis
- ❑ Gout
- ❑ Lupus
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Change in vision, smell, hearing or taste
- ❑ Light headedness
- ❑ Dizziness/vertigo
- ❑ Loss of consciousness
- ❑ Difficulty speaking or swallowing
- ❑ Headaches
- ❑ Numbness or tingling
- ❑ Difficulty walking
- ❑ Change in mood or behavior

Cardiovascular

- ❑ Pacemaker
- ❑ Defibrillator
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Irregular heart beat
- ❑ Heart attack
- ❑ Congestive heart failure
- ❑ TIA
- ❑ Peripheral vascular disease
- ❑ Blood clotting or bleeding disorder
- ❑ Anemia
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Nose bleeds
- ❑ Swollen ankles
- ❑ Redness or swelling of a limb,
- ❑ Unusual bruising
- ❑ Bleeding gums
- ❑ Swollen lymph nodes

Respiratory

- ❑ Asthma
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ COPD
- ❑ Cough or change in cough
- ❑ Blood in sputum
- ❑ Wheezing
- ❑ Difficulty breathing

Digestive

- ❑ Liver disease
- ❑ Hepatitis
- ❑ Ulcers
- ❑ Gall stones
- ❑ Appendicitis
- ❑ Pancreatitis
- ❑ Reflux disease
- ❑ Stomach pain
- ❑ Pain or difficulty swallowing,
- ❑ Indigestion
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bloating
- ❑ Excessive gas or belching
- ❑ Blood in stool
- ❑ Black stools

Genitourinary

- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Prostate enlargement
- ❑ Burning with urination
- ❑ Blood in urine
- ❑ Increased frequency of urination
- ❑ Difficulty with urination
- ❑ Loss of bladder or bowel control
- ❑ Change in menstrual bleeding

____ Initial here if none of the listed symptoms or conditions apply to you.
I have personally read and completed this form. Signature _____