HEALTH FORM

Leaisure Activities:	Occupation:

HEALTH INFORMATION

Last name:	First Name:	Date of Birth: (mm/dd/year)

ALLERGIES: List any medication(s) you are allergic to:	Are you latex sensitive? **YES** **NO**	List any other allergies we should know about:	Have you declared the Advanced Clinical Directive of "Do Not Resuscitate"? **YES** **NO**

Please Check (√) any of the following whose care you're under:

_____ Medical Doctor (MD) _____ Osteopath _____ Dentist	_____ Psychiatrist / Psychologist _____ Physical Therapist _____ Chiropractor	Other:

Date of last physical examination:

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.)

Have you ever been diagnosed as having any of the following conditions?

YES **NO** Cancer. If YES, what kind:
____

YES **NO** Heart Problems. If YES what kind:
____

YES **NO** High Blood Pressure
YES **NO** Circulation Problems
YES **NO** Asthma
YES **NO** Stomach Ulcers
YES **NO** Chemical Dependency (i.e., Alcoholism)
YES **NO** Thyroid Problems
YES **NO** Diabetes
YES **NO** Multiple Sclerosis
YES **NO** Rheumatoid Arthritis
YES **NO** Other Arthritic Conditions
YES **NO** Depression
YES **NO** Hepatitis
YES **NO** Tuberculosis
YES **NO** Stroke
YES **NO** Kidney Disease. If YES, what kind:
____

YES **NO** Blood Clots
YES **NO** Osteoporosis
YES **NO** Other:
____

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During the past month have you been feeling down, depressed or hopeless? **YES** **NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES** **NO**
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES** **NO**

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization.

SURGERIES / HOSPITALZIATIONS - INCLUDE DATE AND REASON:

1.______________________	2.______________________
3.______________________	4.______________________
5.______________________	6.______________________

INJURIES – INCLUDE DATE AND TYPE OF INJURY:

DATE	INJURY	DATE	INJURY
__________	______________________	__________	______________________
__________	______________________	__________	______________________
__________	______________________	__________	______________________

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following:

YES	**NO**	Diabetes	**YES**	**NO**	Cancer
YES	**NO**	Heart Disease	**YES**	**NO**	Alcoholism or Chemical Dependency
YES	**NO**	High Blood Pressure	**YES**	**NO**	Depression
YES	**NO**	Stroke	**YES**	**NO**	Kidney Disease
YES	**NO**	Inflammatory Arthritis (Rheumatoid, Ankylosing)			

Which of the following medications have you taken in the last week:

	PHYSICIAN PRESCRIBED		**NOT PRESCRIBED BY PHYSICIAN**	
Aspirin	**YES**	**NO**	**YES**	**NO**
Tylenol	**YES**	**NO**	**YES**	**NO**
Anti-Inflammatories (Advil/Motrin/Ibuprofen, etc.)	**YES**	**NO**	**YES**	**NO**
Stomach Ulcer Medications	**YES**	**NO**	**YES**	**NO**
Vitamins/Mineral Supplements	**YES**	**NO**	**YES**	**NO**
Herbals/Remedies	**YES**	**NO**	**YES**	**NO**
Others NOT prescribed by a physician:___________				

Please list any other physician-prescribed medication you are currently taking (INCLUDING) pills, injections, and/or skin patches):

1.__________________	2.__________________	3.__________________
4.__________________	5.__________________	6.__________________

How much caffeinated coffee or caffeine containing beverages do you drink per day? ______________________

Tobacco use: How many packs do you smoke per day ________ for how many years ________. If quit, when? ________________

How many days per week do you drink alcohol? __________

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _________

Please circle any of the following that are NEW, UNUSUAL or ATYPICAL for you:

YES	**NO**	Weight Loss/Gain	**YES**	**NO**	Seizures	**YES**	**NO**	Difficulty Breathing
YES	**NO**	Nausea/Vomiting	**YES**	**NO**	Double Vision	**YES**	**NO**	Regular Cough
YES	**NO**	Dizziness/Lightheadedness	**YES**	**NO**	Loss of Vision	**YES**	**NO**	Arm/Leg Swelling

YES	**NO**	Stroke	**YES**	**NO**	Eye Redness	**YES**	**NO**	Heart Racing in your Chest
YES	**NO**	Fatigue	**YES**	**NO**	Skin Rash	**YES**	**NO**	Difficulty Swallowing
YES	**NO**	Weakness	**YES**	**NO**	Problems Sleeping	**YES**	**NO**	Heartburn/Indigestion
YES	**NO**	Fever/Chills/Sweats	**YES**	**NO**	Sexual Difficulties	**YES**	**NO**	Constipation/Diarrhea
YES	**NO**	Numbness or Tingling	**YES**	**NO**	Night Sweats	**YES**	**NO**	Blood in Stools
YES	**NO**	Urinary Incontinence	**YES**	**NO**	Hearing Problems	**YES**	**NO**	Post Menopause
YES	**NO**	Blood in the Urine	**YES**	**NO**	Joint/Muscle Swelling	**YES**	**NO**	Problems Urinating (difficulty starting, painful etc.)
YES	**NO**	Pregnant or think you might be pregnant	**YES**	**NO**	Easy Bruising	**YES**	**NO**	Stress at Home or Work
YES	**NO**	Tremors	**YES**	**NO**	Excessive Bleeding			