HEALTH FORM

Leisure 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 Dire 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 - Please list:

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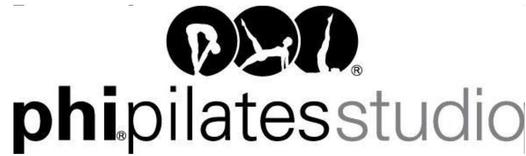
During the past month have you been feeling down, depressed or hopeless? **YES** **NO**



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.____

Additional surgeries/hospitalizations:

INJURIES – INCLUDE DATE AND TYPE OF INJURY:

DATE	**INJURY**	**DATE**	**INJURY**
________________	______________________	________________	______________________
________________	______________________	________________	______________________
________________	______________________	________________	______________________

Additional injuries:

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**

Other Medications 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.____________________

Additional Medications:

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