MEDICAL HISTORY

Name: _____ Date: _____

SYMPTOM HISTORY

Current Problem and Symptoms:

_____

_____

When did your symptoms start? _____

How did your symptoms start? _____

What makes your symptoms feel better? _____

What makes your symptoms feel worse? _____

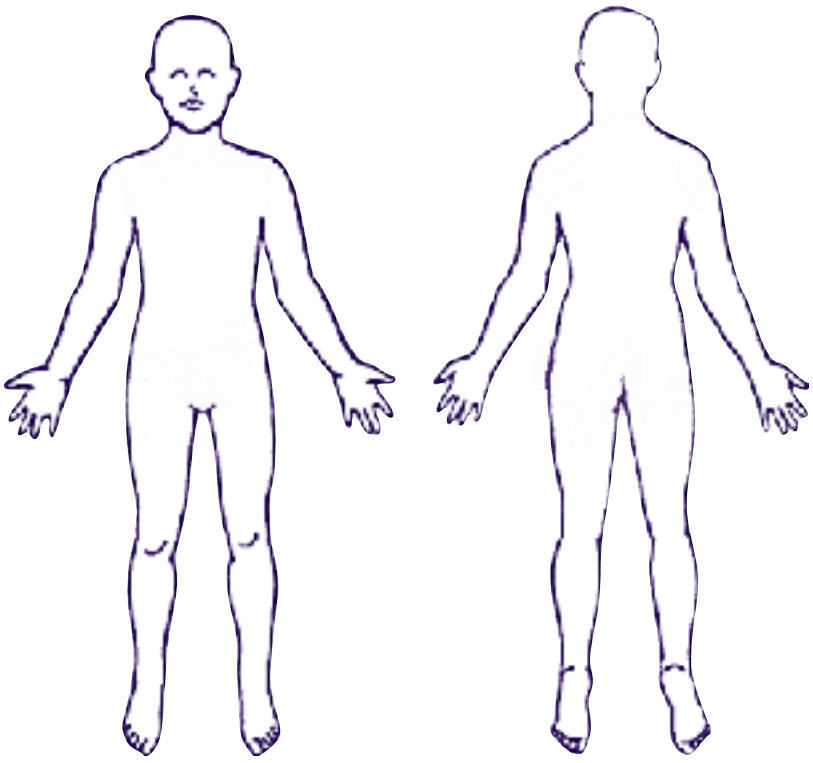
Previous Treatment for Your Current Symptoms:

_____

Treatment Goals:

_____

Use the figures to the right to mark where you have pain or symptoms:



FRONT REAR

Have you been diagnosed with or experienced any of the following:

Diabetes	Yes ☐	Seizure Disorders	Yes ☐
Kidney Disease	Yes ☐	Rheumatoid Arthritis	Yes ☐
Cancer	Yes ☐	Stroke	Yes ☐
Heart Disease/Disorder	Yes ☐	Neurological Disease	Yes ☐
Osteoporosis	Yes ☐	Asthma	Yes ☐
Circulatory Problems	Yes ☐	Blood Disease	Yes ☐
Pacemaker	Yes ☐	High/Low Blood Pressure	Yes ☐
Headaches/Migraines	Yes ☐	Osteoarthritis	Yes ☐
Connective Tissue Disease	Yes ☐	Marfan's or Down's Syndrome	Yes ☐
Crohn's/IBD	Yes ☐	Ankylosing Spondylitis	Yes ☐
Bruise Easily	Yes ☐	Leg/Knee Pain	Yes ☐
Back pain/Hip Pain	Yes ☐	Varicose Veins	Yes ☐
Fibromyalgia	Yes ☐	Numbness/Tingling	Yes ☐
Insomnia	Yes ☐	Fatigue	Yes ☐
Neck Pain	Yes ☐	Blood Clots	Yes ☐
Sciatica	Yes ☐	Pregnant	Yes ☐
Wears Contacts	Yes ☐	Other:	Yes ☐

Current Medications:

_____

_____

Other Pertinent Medical History/Surgeries/Fractures:

_____

_____

Are you currently under the care of any Health Care Provider? Specify purpose.

_____

List any allergies to lotions, oils, fragrances, ointments, or skin sensitivities.

_____

_____

Goals for physical therapy.