Medical History

Name:____Date:____________________________

We collect the following information to assist the therapist in planning your treatment program. This questionnaire allows us to focus on your present problems considering what has happened in the past.

	YES	NO		YES	NO
Osteoarthritis	□	□	Blood Disorder	□	□
Rheumatoid Arthritis	□	□	High Blood Pressure	□	□
Osteoporosis (brittle bones)	□	□	Low Blood Pressure	□	□
Other bone or joint disease	□	□	Heart Attack	□	□
Muscular disorder	□	□	Cardiac Disease	□	□
Stroke	□	□	Angina	□	□
Multiple Sclerosis	□	□	Cardiac pacemaker	□	□
Other neurological disorders	□	□	Disorders of internal organs	□	□
Fainting	□	□	Organ transplant	□	□
Epilepsy	□	□	Heart Valve Replacement	□	□
Anxiety or Depression	□	□	Cancer (past/present)	□	□
Skin disorders	□	□	Communicable disease	□	□
Allergies	□	□	Hepatitis	□	□
Breathing Disorders	□	□	A.I.D.S	□	□
Diabetes	□	□	High dose steroids	□	□
Hemophilia/Blood Clotting Disorder	□	□	Could you be pregnant?	□	□
Thyroid Disorder	□	□	Fear of needles	□	□

I am currently taking:	Yes	No
1. Anti-coagulant medication	□	□
2. Pain medication	□	□
3. Anti-inflammatories	□	□
4. Other		

List:____

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Therapist Signature:_________________________________