RESTORATION BODYCARE

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HEALTH HISTORY

Client Name _____ Date _____

Do you now have, or have you ever had any of the following?

YES	NO	
☐	☐	Diabetes
☐	☐	Hypertension (High Blood Pressure)
☐	☐	Heart Disease
☐	☐	Cancer or tumors
☐	☐	Lung problems
☐	☐	Kidney or liver problems
☐	☐	Arthritis or joint problems
☐	☐	Seizures or nervous disorders
☐	☐	Are you taking any medications? If yes, please list:
☐	☐	Eye problems (e.g. glaucoma, cataracts)
☐	☐	Hernia
☐	☐	Unusual or frequent headaches
☐	☐	Any other health problem not mentioned above? Please describe:
☐	☐	Do you have any family history of any of the above?
☐	☐	Are you pregnant?
☐	☐	Do you have any implants (e.g. joint replacements, pacemaker)?
☐	☐	Are you awakened frequently at night?
☐	☐	Have you ever taken any medication for longer than a few weeks?
☐	☐	Have you ever taken any steroid medications such as cortisone?
☐	☐	Have you ever had steroid injections? For what condition?
☐	☐	Have you ever been hospitalized
☐	☐	Have you ever had surgery?
☐	☐	Have you ever been placed in a cast, splint, ace wrap or sling?
☐	☐	Do you use any shoe lifts, braces, corsets or supports?
☐	☐	Are you currently being treated by any other doctor, therapist, chiropractor, masseuse, podiatrist, or any other person?
		Do you consider your health to be:
		Excellent ☐ Good ☐ Fair ☐ Poor ☐