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HEALTH HISTORY

Are you taking any of the following medications?

☐Nerve Pills ☐Pain Killers ☐Muscle Relaxers ☐Stimulants
☐Blood Thinners ☐Tranquillizers ☐Insulin ☐Other(s)_____

Have you ever had any of the following diseases/medical conditions?

☐ Heart Attack/Stroke	☐Pacemaker	☐Heart Murmur
☐ Congenital Heart Defect	☐HIV+/AIDS	☐Artificial Valves
☐ Alcohol/Drug Abuse	☐Venereal Dis	☐Hepatitis
☐ Frequent Neck Pain	☐Shingles	☐Cancer
☐ High Blood Pressure	☐Emphysema	☐Glaucoma
☐ Low Blood Pressure	☐ Psychiatric Disorder	☐ Anemia
☐ Severe/frequent Headaches	☐Asthma	☐Ulcers/Colitis
☐ Fainting/seizures	☐Arthritis	☐Chemotherapy
☐ Lower Back Pain	☐ Difficulty Breathing	☐ Diabetes
☐ Artificial Bones/Joints	☐Tuberculosis	☐Sinus Problems

Please list any other medical condition(s) you have or ever had:

_____

_____

Please list anything you may be allergic to:

_____

_____

List any accidents with dates:

_____

_____

List all previous surgeries with dates:

_____

_____

Do you exercise regularly? ☐ no ☐ yes/How much?_____ How long?_____

Do you smoke? ☐ no ☐ yes/How much?_____ How long?_____

Are you wearing: ☐Heel lifts ☐Sole lifts ☐Inner soles ☐ Arch supports

What is the age of your mattress? _____ Is it comfortable? ☐ no ☐ yes

For women: Are you taking birth control? ☐ no ☐ yes

Are you pregnant? ☐ no ☐ yes/How far along?_____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient
- Our policy requires payment in full for all services rendered at time of visit, unless other arrangements have been made with the business manager
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____