

Medical History Questionnaire

Name: _____

Date: _____

• **Do you have:**

- Cancer yes no
- Diabetes yes no
- High Blood Pressure yes no
- Heart Disease yes no
- Angina/Chest Pain yes no
- Osteoporosis yes no
- Arthritis yes no
- Stroke yes no
- Joint Replacements/Implants yes no
- Allergies/Asthma yes no
- Headaches yes no
- Breathing Problems yes no
- Kidney Disease yes no
- Ulcers yes no
- Seizures yes no

• **Have you had:**

- Recent Change yes no
in Your Health
- Nausea/Vomiting yes no
- Fever/Chills yes no
- Unexplained Weight Loss yes no
- Dizziness or Falls yes no
- Changes in Bowel yes no
or Bladder Function

Are you currently:

- Pregnant yes no
- Under Stress yes no

• **What are you taking medications for?**

• **What are your goals for therapy?**
