Health History

1. What is your primary complaint (or body part) that you are seeking treatment for?

_____

2. Do you presently or have you ever had any of the following? Check **all** that apply

☐Pacemaker
☐Heart Problems
☐High Cholesterol
☐Pacemaker/devices
☐Stroke
☐Lung Problems
☐Cancer
☐Diabetes
☐Osteoporosis / Osteopenia
☐High Blood Pressure
☐Haemophilia
☐Currently pregnant

☐Arthritis (eg. Rheumatoid)
☐HIV / AIDS
☐Anxiety
☐Chronic Fatigue / Fibromyalgia
☐Repeated Infections
☐Thyroid Problems
☐Skin Disease or Sensitivity
☐Depression
☐Asthma
☐Epilepsy / Seizures
☐DVT

☐ Viral Hepatitis
☐ Liver Disease
☐ Fatigue
☐ Parkinson's Disease
☐ ADHD
☐ Allergies
☐ Digestive Problems
☐ Other
_____
_____
_____

Were you admitted to the hospital for your injury? ☐Yes ☐No Which hospital?_____
Have you been treated previously for injuries sustained? ☐Yes ☐No

3. Please provide a list of any surgeries (including internal pins/wires/artificial joints), past injuries or major dental work you've had:

_____

_____

4. Please provide a list of your current medications:

_____

_____

_____

5. Are you currently taking Anticoagulant ☐Yes ☐No

On a scale from 0-10 what would you rate your current level of pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 Extreme pain

When did your pain begin? _____

Is this a new issue ☐ yes ☐ no

Is this a recurring issue ☐ yes ☐ no

How would you describe your pain?

☐ Sharp stabbing pain
☐ Dull pain
☐ Achy, burning sensation
☐ Pins and needles
☐ Numbness
☐ Other _____

Please shade the affected areas: