Confidential Client Health History

Name ___________________________________ Date ____________________________

Please indicate anything that applies.

Respiratory
__ Chronic Cough
__ Shortness of Breath
__ Smoking
__ Asthma
__ Emphysema
__ Chronic Bronchitis
Notes: ____________________
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Head/Neck
__ Headaches, type ________
__ Vision Problems
__ Earaches
__ Whiplash
__Concussion
Notes: ____________________
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Cardiovascular
__ High Blood Pressure
__ Low Blood Pressure
__ Heart Disease
__ Poor Circulation
__ Phlebitis
__ Varicose Veins
Notes: ____________________
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Skin
__ Eczema
__ Psoriasis
__ Bruise Easily
__ Herpes
Notes: ____________________
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Digestive
__ Difficult Digestion
__ Constipation
__ Diarrhea
__ IBS
__ Crones
__ Colitis
__ Liver Disease
__ Kidney Disease
__ Diabetes, onset ________
__ Gall Bladder
__ Bladder
Notes: ____________________
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Psychological
__ Depression
__ Anxiety
__ Stress Induced Conditions
Notes: ____________________
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Neurological
__ Multiple Sclerosis
__ Loss of Coordination
__ Epilepsy
__ Tingling/Numbness
Notes: ____________________
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____

Surgery
Type _____________________
Date _____________________
Current Symptoms _________
____
____

Injury/MVA
Type _____________________
Date _____________________
Current Symptoms _________
____
____

Other
__ Allergies, type __________
____
__ Arthritis, type ___________
Location _________________
__ STI, type ______________
__ Cancer ________________
____
__ Pregnancy, ______ weeks

Anything Not Addressed:
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