CLIENT HISTORY

NAME:	DOB:
PCP:	
EMERGENCY CONTACT/PHONE:	
OCCUPATION:	
HOBBIES/INTERESTS/ACTIVITIES:	

WHAT BRINGS YOU TO WELL BEINGS TODAY? ____

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MEDICAL HISTORY

DO YOU TAKE ANY MEDICATIONS? PLEASE LIST: ____

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PRIOR SURGERIES/RELATED INJURIES: ____

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IF YOU ARE HERE FOR AN INJURY, WHEN DID IT OCCUR? ____

DID YOU HAVE ANY DIAGNOSTIC TESTING (i.e. X-RAYS, MRI, EMG)? ____

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HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? PLEASE INCLUDE ANY OTHER INFO WE MAY NEED.

	🏳	COMMENTS		🏳	COMMENTS
Allergies			Hearing impairment		
Anxiety/depression			Heart attack/surgery		
Asthma/hay fever			Immune deficiency/disease		
Arthritis			Joint replacement surgery		
Back/neck injury/pain			Kidney disease		
Broken bones/osteoporosis			Liver disease/hepatitis		
Cancer/cyst/tumor			Lung disease/tuberculosis		
Chest pain/heart disease			Pacemaker/defibrillator		
Convulsions/epilepsy			Skin disorders/psoriasis		
Clotting/bleeding disorder			Thyroid disease		
Diabetes			TIA/Stroke		
Eye Injury/glaucoma/cataract			OTHER:		
High Blood Pressure					

INITIAL: __________ DATE: ___________