Medical History (Part 2)

Name:_______________________________________ Date: ____________________

YOUR HISTORY Any of the following that you have ever had:

☐Stroke
☐Heart Disease
☐Chest Pain
☐Respiratory Problems
☐Shortness of Breath
☐Lyme Disease
☐Neurological Problems
☐Parkinsonism
☐Epilepsy/Seizures
☐Nerve Pain
Where____________
☐Paresthesias (prickly, tingling sensation)
☐Numbness
Where_____________
☐Bowel or Bladder Changes
☐Weakness
Where____________

☐Headache/Migraine
☐TMJ/Jaw Dysfunction
☐Joint/Hip Instability
☐Joint Cartilage Degeneration
☐Chronic Joint Pain
☐Recurrent Ankle Sprains
☐ Torn Knee Cartilage
☐Bruising
☐Fractures (any)
☐Increased Flexibility as a Child
☐Back Pain
☐Scoliosis
☐Muscle/Joint Pain and/or Stiffness
☐Carpal Tunnel
☐Autoimmune Disease
☐Raynaud's Syndrome

☐Flat Feet
☐Plantar Fasciitis
☐Bunion
☐Arthritis
☐Varicose Veins
☐Hernia
☐Uterine/Rectal Prolapse
☐Leg Length Difference
☐Pelvis Unlevel/Rotated
☐Gout
☐Anxiety
☐Psychological Problems
☐Weight Change
How Much _____
Over What Time______
☐Thyroid
Hypo___Hyper___

↓ or have now↓

☐Diabetes
☐Eye Problems
☐Digestive Disorders
☐Abdominal Pain
☐Vomiting
☐Diarrhea
☐Nausea
☐Constipation
☐Rashes
☐ Night sweats
☐Fever
☐Chills
☐Fatigue
☐Candida
☐Other ___________

FAMILY HISTORY (Any of which affected your parents, grandparents, siblings, or children):

CONDITION	Relative(s) Affected	CONDITION	Relative(s) Affected
☐Genetic Disease	____________________	☐Scoliosis	____________________
☐Allergies	____________________	☐Gout	____________________
☐Arthritis	____________________	☐Headache/Migraine	____________________
☐Heart Disease	____________________	☐Bleeding Problems	____________________
☐Overweight	____________________	☐Depression	____________________
☐Stroke	____________________	☐Osteoarthritis	____________________
☐Diabetes	____________________	☐Thyroid Disease	____________________
☐Digestive/GI	____________________	☐Suicide/Suicidal	____________________

ACTIVITY LEVEL

☐Sedentary (inactive) by choice
☐Sedentary (inactive) due to inability or restriction
☐Light (light daily work and no regular exercise)
☐Moderate (light daily work and exercise 3x a wk)
☐Sustained (moderate daily work and exercise 5x a wk)
☐Heavy (heavy work and heavy exercise 5x a wk)

ACTIVITY TYPE

☐Running/Jogging
☐Swimming
☐Soccer
☐Cycling
☐Softball
☐Basketball
☐Weight lifting
☐Pilates
☐Football
☐Tennis
☐Racquetball
☐Hiking
☐Baseball
☐Yoga
☐Aerobics
☐Other__________

STRESSORS Affecting Your Life

☐Difficulties with work or lifestyle
☐Illness- personal
☐Other__________________________