Date:_____

Medical Conditions & History

Primary Physician's Name & Phone #:_____

Please mark in the appropriate box if you currently have or have had in the past any of the following conditions .

List approximate dates & body locations when applicable & any medication, vitamins, herbs or supplements you are taking.

Date	Past	Current	Location(s)	Medication/Supplement	**(Please circle all that apply)**
					Allergies/Asthma/Sinus
					Emphysema/COPD
					Any Skin Problem
					Heart Ailment
					TMJ Syndrome
					Blood Pressure: high low
					Dizziness
					Diabetes
					Kidney Ailment
					HIV
					Any Contagious Disease
					MRSA
					Seizures
					Cancer/Tumors
					Mastectomy/Lymphedema
					Numbness/Tingling
					Depression/Anxiety
					Blood Clots
					Varicose Veins
					Stroke
					Abdominal Pain
					Breast Implant/Reduction
					Recent Illness/Surgery
					Joint Replacement
					Recent Fractures
					Headaches
					Osteoporosis
					Arthritis
					Chronic Pain
					Spinal/Back Problems
					Neck Problems
					Whiplash
					Car Accidents/Major Trauma
					Autoimmune Dysfunction
					Sleep Disorders

Therapist Notes