



WASHINGTON WELLNESS CENTER

CONFIDENTIAL MEDICAL HISTORY

Patient's Name _____ Date _____

Please check any of the following conditions you have had

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Concussion | <input type="checkbox"/> Joint disease | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Head injury | <input type="checkbox"/> Polio | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bone disease | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Respiratory problems | _____ |

Have you ever had:

- | | | | | |
|--------------------|-----------------------------|------------------------------|-------------|----------------|
| Back surgery | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ | By Whom? _____ |
| Neck surgery | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ | By Whom? _____ |
| Surgical implants | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ | By Whom? _____ |
| Any other surgery? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ | By Whom? _____ |

Please list any medications you now take _____

Are you wearing Heel lifts Arch supports Inner soles Sole lifts

Have you ever been involved in an auto accident, work related accident or other mishap (eg. fall)? No

Yes (Please describe: When, injuries sustained, etc...) _____

List any family members with significant health problems

Name	Relation	Past & Present Health Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever:

- | | | |
|--|-----------------------------|--|
| Been knocked unconscious? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Used a cane, crutch or other support? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____
<i>(If yes, please describe briefly)</i> |
| Been treated for a spine or nerve disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Had a fractured or dislocated bone? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| Been hospitalized for other than surgery? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |

Do you:

(If yes, please list/explain)

- Now take vitamins or minerals? No Yes _____
- Have an allergy to any drug or food? No Yes _____
- Have any congenital or hereditary conditions? No Yes _____
- Use alcohol? No Yes _____
- Coffee / Caffeine? No Yes _____
- Tobacco? No Yes _____
- Drugs? No Yes _____
- Exercise regularly? (list type of exercise) No Yes _____
- Participate in any sports activities? No Yes _____

My current complaints involve:

- | | | | |
|--|--------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder(s) | <input type="checkbox"/> Arm(s) |
| <input type="checkbox"/> Elbow(s) | <input type="checkbox"/> Wrist(s) | <input type="checkbox"/> Hand(s) | <input type="checkbox"/> Finger(s) |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Mid Back | <input type="checkbox"/> Low Back | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Abdomen/Stomach | <input type="checkbox"/> Hip(s) | <input type="checkbox"/> Leg(s) | <input type="checkbox"/> Knee(s) |
| <input type="checkbox"/> Foot / Feet | <input type="checkbox"/> Other _____ | | |

Symptoms began on or about _____ (day / date)

Symptoms may be resultant from:

- Auto accident Accident at work Athletic Activity Unknown
- Other (Explain) _____
- _____
- _____

Personal Information

Family Physician _____ Phone _____

In case of emergency, please notify

Name _____ Relationship _____

Home Phone () _____ Work Phone () _____

To my knowledge, the information provided above is accurate.

Guardian Signature _____ Date _____