



Health History

Name _____

Please mark the following conditions that apply to you currently (○) and/or in the past (P)

Musculo-skeletal

- P Arthritis
- P Back pain
- P Bone or joint disease
- P Broken/Fractured bones
- P Headaches
- P Jaw pain/TMJ
- P Scoliosis
- P Strains/Sprains
- P Tendonitis
- P (Other) _____

Circulatory System

- P Blood clots
- P Heart disease
- P Hypertension
- P Low blood pressure
- P Stroke
- P Swollen feet/ankle
- P Varicose veins
- P _____

Cancer

- P _____

Skin

- P Allergies
- P Athletes' Foot
- P Rash
- P _____

Respiratory

- P Allergies
- P Asthma
- P Sinus problems
- P _____

Digestive

- P Constipation
- P Diarrhea
- P Indigestion
- P Gas, bloating
- P _____

Mental Health

- P Anxiety
- P Depression
- P _____

Reproductive

- P PMS
- P Pregnancy
- P Menopause
- P _____

Other

- P Diabetes
- P Fatigue
- P Fibromyalgia
- P Numbness/tingling
- P Sleeping problems

Please list any infectious diseases

Please list any disabilities

Please list any surgeries

Please list any traumas/accidents

Please list any medications

Please list any allergies

Do you currently have any incisions, open wounds, drains, or dressings? _____

Have you ever had or are you at risk of developing lymphedema? _____

Is there anything else about your medical history that I should know? _____

I have marked any and all conditions that I am aware of and I assert that this information is true and accurate. I will inform the health care provider of any changes in my status.

Client signature _____ Date _____

Parent signature _____ Date _____

Therapist's Notes:
