CLIENT MEDICAL HISTORY

Client Name: ______________________________ Date: ______________

Place a check in the box as it applies to you:

HEALTH CONDITION	FREQUENCY LEVEL			
	Mild	Moderate	Severe	N/A or Description
Allergies	☐	☐	☐	
Arthritis/Limited Joint Movement	☐	☐	☐	
Asthma/Hayfever/ Respiratory/Colds/ Trouble Breathing	☐	☐	☐	
Astigmatism/ Farsighted/Nearsighted/ Glasses/Contacts				
Bursitis	☐	☐	☐	
Cancer/Tumors	☐	☐	☐	
Carpal Tunnel/Tarsal Tunnel	☐	☐	☐	
Circulatory Problems	☐	☐	☐	
Cleansing Programs/ Colonics, Fasting, Herbal Programs, Diets	☐	☐	☐	
Colitis	☐	☐	☐	
Constipation	☐	☐	☐	
Depression/Anxiety	☐	☐	☐	
Diabetes	☐	☐	☐	
Epilepsy/Blackout	☐	☐	☐	
Fatigue/Insomnia	☐	☐	☐	
Fractures/Broken Bones	☐	☐	☐	
Gall Bladder/Stones	☐	☐	☐	
Gout	☐	☐	☐	
Hearing Loss/ Mastoid, Ear Problems	☐	☐	☐	
Heart Disease/Hypertension	☐	☐	☐	
Hypoglycemia	☐	☐	☐	
Indigestion/Bloating/Gas	☐	☐	☐	
Kidney/Ureter/Bladder	☐	☐	☐	

HEALTH CONDITION	FREQUENCY LEVEL			
	Mild	Moderate	Severe	N/A or Description
Lower/Upper Back Pain/ Sciatic Pain	☐	☐	☐	
Lymphatic/Cysts	☐	☐	☐	
Migraines/Headaches	☐	☐	☐	
Muscle Aches/Cramps	☐	☐	☐	
Muscle Strains/Sprains	☐	☐	☐	
Arthritis/ Rheumatoid Arthritis/ Osteoarthritis	☐	☐	☐	
Sinus Troubles/ Tonsillitis/Sore Throats/ Laryngitis w/colds	☐	☐	☐	
Skin Disease/Irritations	☐	☐	☐	
Speech Problems	☐	☐	☐	
Spinal/Disc Problem	☐	☐	☐	
Tendonitis	☐	☐	☐	
Thrombosis	☐	☐	☐	
Thyroid Troubles	☐	☐	☐	
TMJ	☐	☐	☐	
	☐	☐	☐	
Ulcers	☐	☐	☐	
Varicous Veins	☐	☐	☐	
Vertigo/Dizziness	☐	☐	☐	
Weight Control	☐	☐	☐	

List any surgeries (details) ______________________________

____

____

How many children do you have? __________ Ages __________

Do you smoke? __________ If yes, how many/how often? __________ Per __________

What is a typical breakfast for you? ______________________________

What is a typical lunch for you? ______________________________

What is a typical dinner for you? ______________________________

Current Occupation: ______________________________ How long there? __________

Previous Occupation: ______________________________ How long there? __________