



Medical History and Systems Review

Name _____ Date _____
D.O.B. _____ Age _____ Female () Male ()

Has your height or weight changed in recent months/years? _____
Overall Physical Condition: [] Poor [] Fair [] Good [] Excellent

Occupation _____ Leisure Activities _____
Do you exercise beyond normal daily activities and chores? [] Yes [] No

Describe the reason for your visit: _____

Date of Injury/Onset _____ Onset (check one): [] Gradual [] Sudden
How did the problem occur? _____

Describe the pain: [] Dull [] Sharp [] Constant [] Intermittent
[] Sore [] Throbbing [] Bruised [] Burning

Have you had any similar problems in the past? _____

Are you CURRENTLY seeing any of the following?

Table with 3 columns: Professional, YES, NO. Rows include Medical Doctor, Osteopath, Dentist, Physical Therapist, Psychiatrist/Psychologist, Chiropractor.

Please list any surgeries or hospitalizations and the approximate dates and reasons:

Table with 2 columns: Date, Surgery/Hospitalization/Reason. Includes four rows for data entry.

Please describe any major injuries for which you have been treated:

Table with 2 columns: Date, Injury. Includes four rows for data entry.

InsideOut

B O D Y T H E R A P I E S

Date of Last Complete Medical Exam: _____ Physician _____

Women Only: Are you pregnant? ____ Date of last delivery? ____ # of Pregnancies ____

Please list all PRESCRIPTION medications you are currently taking: _____

Have you ever been DIAGNOSED as having:

- | | | |
|---|--|--|
| <input type="checkbox"/> Cancer (Type: _____) | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Psychiatric Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Bowel Problems |
| <input type="checkbox"/> Emphysema/C.O.P.D. | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Urinary/Bladder Control |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Vision/Hearing | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> HIV/AIDS | |
| <input type="checkbox"/> Osteoarthritis | | |

Check any CURRENT symptoms:

- | | | |
|--|--|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Weakness | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever/Night Sweats | <input type="checkbox"/> Other Pain |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Limited Movement |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Night Pain | |
| <input type="checkbox"/> Coordination Problems | <input type="checkbox"/> Cough/Hoarseness | |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Difficulty Swallowing | |

Please mark on the figures, the areas where you are experiencing pain.

