❑ E. Arlington ....646-1144 • fax: 928-0039
CWTS ❑ JB ❑ EA ❑ M

MEDICAL HISTORY SHEET

NAME: ______________________ OCCUPATION: ______________________

HOME PHONE: ______________________ AGE: __________ DATE OF BIRTH: __________

IN CASE OF EMERGENCY NOTIFY: ____

(NAME) (PHONE)

CIRCLE YES OR NO (FURTHER DESCRIBE YES ANSWER TO RIGHT)

YES NO HISTORY OF HIGH BLOOD PRESSURE ______________________

YES NO HISTORY OF HEART OR BLOOD VESSEL DISEASE ______________________

YES NO PREVIOUS HEART ATTACK - M.I. ______________________

YES NO PREVIOUS STROKES - C.V.A. ______________________

YES NO DIABETES ______________________

YES NO EPILEPSY ______________________

YES NO RESPIRATORY DIFFICULTIES ______________________

YES NO BROKEN BONES ______________________

YES NO NUMBNESS & TINGLING ______________________

YES NO ARTHRITIS OR JOINT PROBLEMS ______________________

YES NO SPECIAL DIET RESTRICTIONS ______________________

YES NO PRESENTLY HAVE ANY METAL IMPLANTS ______________________

YES NO CURRENTLY PREGNANT ______________________

YES NO ANY PRESENT VISUAL PROBLEMS ______________________

YES NO ANY PRESENT HEARING PROBLEMS ______________________

YES NO ANY UNUSUAL REACTION TO HEAT OR COLD ______________________

YES NO ANY ALLERGIES ______________________

YES NO ANY LIMITATION IN YOUR ACTIVITIES ______________________

YES NO DO YOU HAVE ANY BOWEL OR BLADDER PROBLEMS ______________________

YES NO DO YOU REQUIRE SPECIAL HELP AT HOME ______________________

YES NO LIST CURRENT MEDICATIONS ______________________

YES NO LIST PREVIOUS MAJOR HOSPITALIZATION/SURGERIES ______________________

YES NO LIST USUAL RECREATIONAL ACTIVITIES ______________________

YES NO HISTORY OF CANCER ______________________

YES NO HISTORY OF IMMUNE DISORDER OR COMMUNICABLE DISEASE ______________________

DATE OF NEXT DOCTORS VISIT ______________________

______________________ ______________________

(DATE) SIGNATURE THERAPIST'S SIGNATURE