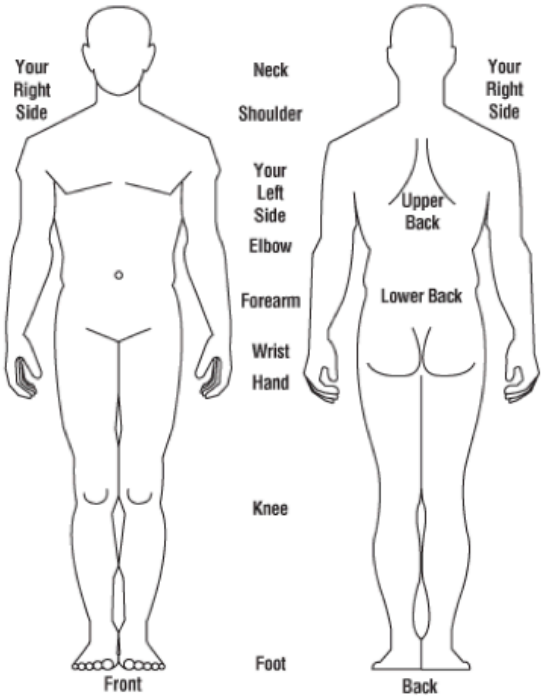
Health History Questionnaire: **Name:** _____

DO you NOW have or have you EVER HAD:

- ☐ arthritis
- ☐ cancer
- ☐ diabetes
- ☐ parkinson's
- ☐ joint replacements; pins, wires
- ☐ stroke
- ☐ osteoporosis
- ☐ high blood pressure
- ☐ heart attack
- ☐ nervous tension
- ☐ neck, spine injuries
- ☐ decreased range of motion
- ☐ fusions
- ☐ depression
- ☐ disk problems
- ☐ back pain
- ☐ joint ache
- ☐ numbness
- ☐ varicose veins
- ☐ spider veins
- ☐ blood clots
- ☐ blood thinner
- ☐ whiplash
- ☐ asthma
- ☐ epilepsy/ seizures
- ☐ tuberculosis
- ☐ hepatitis
- ☐ easily bruised
- ☐ broken bones
- ☐ surgery, describe _____
- ☐ joint swelling
- ☐ present injuries
- ☐ allergies
- ☐ incontinence
- ☐ other _____
- ☐ smoke / (ed) How long? _____
- ☐ accident, describe _____

Mark on the drawing where you feel pain or have limitations



I have read the above information and have stated all my previous and current known medical conditions. I take it upon myself to update my instructor regarding any changes in my condition.

STUDENT SIGNATURE _____ **DATE** _____