InsideOut
BODY THERAPIES

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?

Medical Doctor	YES	NO
Osteopath	YES	NO
Dentist	YES	NO
Physical Therapist	YES	NO
Psychiatrist/Psychologist	YES	NO
Chiropractor	YES	NO

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

Date	Surgery/Hospitalization/Reason
_____	_____
_____	_____
_____	_____
_____	_____

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

Date	Injury
_____	_____
_____	_____
_____	_____
_____	_____

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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: _____
_____

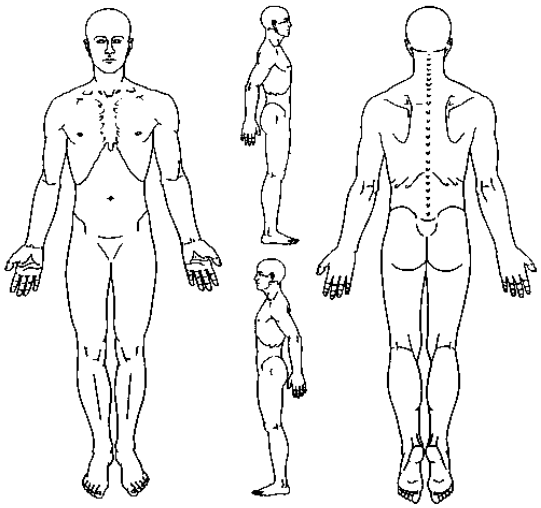
Have you ever been DIAGNOSED as having:

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

Check any CURRENT symptoms:

__ Chest Pain
__ Shortness of Breath
__ Heart Palpitations
__ Fatigue
__ Ankle Swelling
__ Dizziness
__ Coordination Problems
__ Loss of Balance
__ Difficulty Walking
__ Numbness/Tingling
__ Weakness
__ Fever/Night Sweats
__ Difficulty Sleeping
__ Night Pain
__ Cough/Hoarseness
__ Difficulty Swallowing
__ Muscle Pain
__ Abdominal Pain
__ Joint Pain
__ Other Pain
__ Limited Movement

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



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