TARA TC CRITES

HEALTH HISTORY

Name: ______________________ Date: __________

Have you ever experienced, or been treated by a physician for:

______ heart disease
______ heart palpitations
______ high blood pressure
______ gastric reflux
______ asthma
______ vertigo
______ glaucoma
______ orthopedic or joint problems: shoulder / elbow / wrist / spine / hip / knee / ankle / foot
______ osteoporosis/osteopenia
______ arthritis
______ peripheral neuropathy (numbness / tingling / diminished sensation)

Date of last physical: ______________________

Name of primary physician:

City: ______________ Phone: ______________

Do you carry a list of medications? Yes No

Name other health care professionals (nutritionist, chiropractor, physical therapist, etc.)

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Females: Are you currently pregnant? Yes No Do you plan to get pregnant? Yes No

Previous children born cesarean or normal delivery? ______________

Date(s) of cesarean section(s) ______________

Any prior surgeries or injuries? Ex: abdominal surgeries, hip/knee replacement, fused vertebrae, etc.

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Do you have any injuries or limitations? ______________

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