MEDICAL HISTORY FORM

Name: _____

Occupation: _____

Have you at any time been diagnosed as having any of the following conditions?

___Cancer, if yes, what kind? _____
___Heart problems
___Circulatory Problems
___Bleeding Disorders
___Epilepsy
___Anemia
___Kidney Disease
___Asthma
___Emphysema/Bronchitis
___Chemical Dependency
___High Blood Pressure
___HIV
___Thyroid problems
___Multiple Sclerosis
___Rheumatoid Arthritis
___Other Arthritic conditions
___Depression
___Hepatitis
___Tuberculosis
___Stroke
___Other _____

Please list any prescription pills, injections and/or skin patches you are currently taking?

_____ _____

_____ _____

_____ _____

Please describe any other health issues that we should know about.

Patient signature: _____ Date: _____

Therapist signature: _____ Date: _____