Date _____

Last Name _____ First_____ DOB_____

Address _____ City_____ State _____ ZIP _____

Phone _____ Email _____

Emergency Contact _____ Phone _____

Relationship To Client _____

Medical History

Please list all current medications (Rx and OTC), supplements, herbals, and their reason for use. Attach additional pages as necessary.

_____

_____

_____

_____

Please list any past surgeries or injuries and dates of each

_____

_____

_____

_____

Is there any other relevant information you wish to make Neil aware of today?

_____

_____

_____

_____

Continued On Reverse

Please check any of the following that apply to you and please provide dates

Musculoskeletal
___ Bone or Joint Disease
___ Osteoporosis/Osteopenia
___ Fractures/Dislocations
___ Joint Replacement
___ Tendonitis/Bursitis
___ Arthritis
___ Disc Rupture/Herniation
___ Sprains/Strains
___ Adhesive Capsulitis/Frozen Shoulder
___ Scoliosis
___ Other _____

Neurological
___ Nerve Entrapment/Impingement
___ Epilepsy/Seizure Disorder
___ Multiple Sclerosis
___ Parkinson's Disease
___ Degenerative Neurological/Brain Disease
___ Other _____

Circulatory
___ Heart Disease/Heart Attack
___ High/Low Blood Pressure
___ Thrombosis/Embolism/Blood Clots
___ Lymphedema
___ Other _____

Respiratory
___COVID-19
___ Allergies/Sinus
___ Asthma
___ Bronchitis
___ COPD
___ Emphysema
___ Cystic Fibrosis
___ Other _____

Endocrine
___ Diabetes/Hypo/Hyperglycemia
___ Hypo/Hyperthyroidism
___ Cushing's Disease
___ Addison's Disease
___ Hypercalcaemia
___ Systemic Lupus
___ Parathyroid Disease
___ Other _____

Digestive
___ Acid Reflux/Heartburn
___ GERD
___ Celiac Disease
___ Crohn's Disease
___ IBS
___ Ulcerative Colitis
___ Gallstones
___ Diabetes
___ Other _____

Skin
___ Allergies
___ Dermatitis
___ Eczema
___ Psoriasis
___ Athlete's Foot/Fungal
___ Herpes/Cold Sores
___ Other _____

Cancers
___ Breast
___ Lung
___ Colorectal
___ Leukemia
___ Kidney/Bladder
___ Liver
___ Brain
___ Gynecologic/Prostate/Testicular
___ Other _____

Reproductive
___ Endometriosis
___ Fibroids
___ Prostate Disorders
___ HIV/AIDS/STDs
___ Other _____

Emotional/Psychological
___ Anxiety/Stress Related Disorders
___ Depression
___ Insomnia/Sleep Disorders
___ Migraines/Headaches
___ Eating Disorders
___ Drug/Alcohol Dependency
___ Abuse/Trauma