Client Medical Information

(Please print all but your signature. Thank you!!)

Client Name: _____ Date of First Visit: _____

Physician Name: _____

Address: _____

Phone: (_____)_____ Date of last visit: _____

Please provide the following information (use back of page if more space needed):

1. General medical illnesses that I have had (for example, cancer, diabetes, arthritis, heart problems, thyroid problems, migraines, chronic fatigue syndrome, spinal cord issues, etc.)

   _____

   _____

   _____

2. Significant injuries or surgeries, and any information about recovery complications or outcomes (in particular, please indicate any history of head injury).

   _____

   _____

   _____

3. Prescriptions or over-the-counter medications I take regularly (Please include dosages, frequency, and prescriber if different than above Physician).

   _____

   _____

   _____

   _____

4. Allergies I have to foods, medications, and other things.

   _____

   _____

   _____

5. General medical illnesses that have run in my family (i.e., cancer, diabetes, heart disease, etc.).

   _____

   _____

   _____

6. How would you rate your physical health (excellent, good, fair, poor)? Other notes about my health.

   _____

   _____

   _____