AO Wellness Center: Client Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition that you've listed.

Musculo-Skeletal

- ☐ Headaches
- ☐ Joint Stiffness/Swelling
- ☐ Spasms/Cramps
- ☐ Broken/Fractured Bones
- ☐ Strains/Sprains
- ☐ Back, hip pain
- ☐ Shoulder, neck, arm hand pain
- ☐ Leg, foot pain
- ☐ Chest, ribs, abdominal pain
- ☐ Problem walking
- ☐ Jaw pain/TMJ
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone or Joint Disease
- ☐ Other _____

Circulatory and Respiratory

- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Cold sweats
- ☐ Swollen ankles
- ☐ Pressure sores
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Sinus problem
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedema
- ☐ Other _____

Skin

- ☐ Rashes
- ☐ Athlete's Foot
- ☐ Warts
- ☐ Moles
- ☐ Acne
- ☐ Cosmetic surgery
- ☐ Other _____

Digestive

- [ ] Nervous Stomach
- [ ] Indigestion
- [ ] Constipation
- [ ] Intestinal Gas/Bloating
- [ ] Diarrhea
- [ ] Diverticulitis
- [ ] Irritable Bowel Syndrome
- [ ] Crohn's Disease
- [ ] Colitis
- [ ] Adaptive Aids
- [ ] Other

Nervous System

- [ ] Numbness/tingling
- [ ] Twitching of face
- [ ] Fatigue
- [ ] Chronic Pain
- [ ] Sleep Disorders
- [ ] Ulcers
- [ ] Paralysis
- [ ] Herpes/Shingles
- [ ] Cerebral Palsy
- [ ] Epilepsy
- [ ] Chronic Fatigue Syndrome
- [ ] Multiple Sclerosis
- [ ] Muscular Dystrophy
- [ ] Parkinson's Disease
- [ ] Spinal Cord Injury
- [ ] Other

Reproductive System

- [ ] Current pregnancy
- [ ] Past pregnancy
- [ ] PMS
- [ ] Menopause
- [ ] Pelvic inflammatory disease
- [ ] Endometriiosis
- [ ] Hysterectomy
- [ ] Fertility Concerns
- [ ] Prostate Problems
- [ ] Other

Other

- [ ] Loss of appetite
- [ ] Forgetfulness
- [ ] Confusion
- [ ] Depression
- [ ] Difficulty concentrating
- [ ] Hearing impaired
- [ ] Vision Impaired
- [ ] Burning during urination
- [ ] Bladder infection
- [ ] Eating disorder
- [ ] Diabetes
- [ ] Fibromyalgia
- [ ] Post-polio syndrome
- [ ] Cancer

Nicotine Use

Drug Use

Caffeine Use

Alcohol Use

Surgeries

Infectious disease (please list)

Other congenital or acquired disabilities (please list)

Please list all allergies

Other

Please list any additional comments regarding your health and well-being

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Signature

Date