



Date: _____

CCPT Confidential Health History Form

Patient Name _____

Present Symptoms / what is your major complaint? _____

Minor complaints / other areas of concern _____

When did you first notice major complaint? _____

What brought it on? _____

What activities aggravate condition? _____

Is this condition interfering with your work? ____ No ____ Yes ____ Constant ____ Comes and goes

What do you believe is wrong with you? _____

What have you done to get relief? _____

Has there been a medical diagnosis? ____ No ____ Yes / Drs. Diagnosis _____

____ X-Ray? ____ Scan? ____ MRI? ____ Blood work? Describe _____

Related History:

Have you ever had this problem before? ____ No ____ Yes - If yes, when? _____ What caused those episodes?

What relieved them? _____

Did they disable you? ____ No ____ Yes Did they prevent you from working? ____ No ____ Yes Hospitalize you? ____ No ____ Yes

What was the previous diagnosis? _____ What were the treatments? _____

_____ Did they help? ____ No ____ Yes

Are you on any medications? ____ No ____ Yes If yes, list them: _____

Are you taking any of the following? (please circle all that apply):

- Laxatives Sedatives Aspirin Pain Medication (NSAID's)
- Vitamins Minerals Herbs Sleeping pills Insulin

Habits: Heavy Moderate Light None

- | | | | | |
|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coffee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tea (caffeinated) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sugar Consumption | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Soda Pop | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Have you ever:

Had any operations? ____ No ____ Yes/Describe _____

Broken any bones? ____ No ____ Yes/Describe _____

Been in an accident? ____ No ____ Yes/Describe _____

Did you receive a whiplash? ____ No ____ Yes

(Please circle all that apply) I primarily sleep on my: Side

Back

Stomach

(Please circle all that apply) Do you wear:

Heel lifts?

Orthotics?

Arch supports?

Inner soles?

(Please circle all that apply) Do you have difficulty with any of the following:

- | | | | | |
|-----------------|-----------------------|-------------------|---------------------|----------------------------|
| Headaches | Muscle spasm in neck | Cold sweats | Shooting head pains | Gall bladder trouble |
| Loss of smell | Neuritis | Indigestion | Hay fever | Pins/needles in arms/hands |
| Intestinal gas | Asthma | Cold Hands | Constipation | Loss of taste |
| Chest pains | Kidney trouble | TB | Diabetes | Inflammation of throat |
| Thyroid trouble | Heart disease | Cancer | Face flushed | Heart palpitation or pain |
| Sleep disorder | Muscle twitching | Heart attacks | Joint pain | Memory loss |
| Swollen joints | High blood pressure | Fatigue | Arthritis | Depression |
| Anemia | Low blood pressure | Slipped disc | Rheumatic fever | Head feels too heavy |
| Dizziness | Nervous stomach | Fainting | Stomach trouble | Pins and needles/legs |
| Ulcers | Cold feet | Irritability | Loss of balance | Pinched nerve in back |
| Loss of balance | Ringling in ears | Inner tension | Light sensitivity | HIV/Aids |
| Nervousness | Wear glasses/contacts | Pain in legs/feet | TMJ/Jaw pain | |

Other (please explain)