MEDICAL DETAILS • CONFIDENTIAL

To ensure you receive a complete and thorough evaluation, please provide us with the important background medical information. If you do not understand a question, your therapist will assist you

NAME:_____ **DATE:**_____

Have you ever been diagnosed as having any of the following conditions? Please tick the appropriate answer and indicate the name of the medication (if any) you are taking for each condition.

MEDICATION/ADDITIONAL INFORMATION:

YES☐ NO☐Cancer (if yes, describe what kind)……..

YES☐ NO☐Heart problems or high/low blood pressure……..

YES☐ NO☐Allergies……..

YES☐ NO☐Respiratory problems or Tuberculosis…..……..

YES☐ NO☐Thyroid Problems……..

YES☐ NO☐Diabetes……..

YES☐ NO☐Rheumatoid arthritis……..

YES☐ NO☐Osteoporosis……..

YES☐ NO☐Other arthritic conditions……..

YES☐ NO☐Hepatitis……..

YES☐ NO☐Pacemaker or Hearing Aid……

YES☐ NO☐Stroke……..

YES☐ NO☐Kidney disease……

YES☐ NO☐Stomach Ulcers……..

YES☐ NO☐Epilepsy……

YES☐ NO☐Bowel or bladder problems……..

YES☐ NO☐Cholesterol problems……..

YES☐ NO☐Recent Surgeries……..

YES☐ NO☐Pregnant……

OTHER……..

Are you on any of the following medication: (please specify which medication)

YES☐ NO☐Painkillers……

YES☐ NO☐ Anti-Inflammatories……

YES☐ NO☐ Hormone Replacement Therapy (HRT)……

YES☐ NO☐ Other: Antibiotics, Ruacutane, Statins, Anti-coaguants?……...

YES☐ NO☐ Have you ever taken any long term course of steroids/cortisone?

YES☐ NO☐ Have you had a bone density scan?

YES☐ NO☐ Have you had recent weight loss? **Signature**_____

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