

**Cardiovascular:**

- high blood pressure
- low blood pressure
- heart attack
- phlebitis/varicose veins
- stroke
- pacemaker
- family history of heart disease
- history of heart attack
- congestive heart failure

**Head and Neck:**

- vision problems
- ear problems
- hearing loss
- headaches  migraines
- frequent colds
- sinus problems

**Muscles/joints:**

- pain  arm R/L
- stiffness  elbow R/L
- swelling  hand R/L
- limited movement  leg R/L
- neck  hip R/L
- low  mid  upper back  thigh R/L
- shoulder R/L  knee R/L

**Skin:**

- skin conditions
- rash/eruptions
- cold sores
- herpes
- contagious conditions
- bruise easily

**Infections:**

- hepatitis
- HIV
- TB

**Digestive:**

- loss of appetite
- poor appetite
- constipation/diarrhea
- liver/gallbladder
- nausea  gas
- excessive appetite

**Uro/Genital:**

- frequent urination
- kidney/bladder

Surgeries(year/  
type): \_\_\_\_\_

Accidents(year/  
type): \_\_\_\_\_

Do you have any other complaints that you have not described?  
explain: \_\_\_\_\_

I acknowledge that the therapist explained everything fully and has given me the opportunity to ask any questions. I have read and understand the above information and give my consent to receive treatment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_