Health History **C y m a t h e r a p y[SM]®**

Name: _____Date: _____Time: _____

Height:_____Weight:_____DOB:_____ Gender: __Male __Female

Address:_____City/State/Zip:_____

Home Phone:_____Work Phone:_____

Cell Phone:_____E-mail:_____

Occupation:_____

*Physician:_____ Phone:_____

Address:_____

Date of last visit:_____ For What Condition?_____

Has your physician given any diagnosis of a specific condition? _____ What condition?_____

Has your physician diagnosed an autoimmune disease? _____ What condition?_____

Are you aware of any inflammatory process in your body? _____

What symptoms are you experiencing? _____

*Your physician will be contacted should more information regarding your health be needed.

Are other physicians or healthcare practitioners assisting you in your healthcare plan? If so, please list their name, area of specialty and contact information:

Practitioner Name:_____

Address: _____

Area of specialty: _____Date of last visit _____Phone:_____

Practitioner Name:_____

Address: _____

Area of specialty: _____Date of last visit _____Phone:_____

Use reverse side of page to list additional practitioners on your healthcare team.

In Case of Emergency Please Notify:

Name:_____

Relationship:_____

Address:_____

Phone:_____

1. Are you under the care of a physician, chiropractor, or other healthcare provider for ANY reason? ___YES ___NO If yes, please list reason:

_____

_____Date of last visit: _____

2. Are you taking any medications? ___YES ___NO If yes, please list.
NAME DOSE / FREQUENCY

_____

_____

_____

3. Do you have any allergies? ___YES ___NO If yes, please list:

_____

_____

4. Are you pregnant? ___YES ___NO ___N/A

5. Do you have any implanted medical devices such as: a Pacemaker / Defibrillator,

Insulin pump or Infusion Device to dispense pain medication? ___Yes ___No If yes, indicate device:_____

6. Has your doctor or healthcare provider ever told you that you have a bone, joint or muscle problem? If so, please explain it in your own words.

_____

7. Have you had any previous surgeries? ___YES ___NO If yes, please list surgeries and date of surgery:

_____

_____

8. Have you ever experienced any chest pain or discomfort? ___YES ___NO

9. Do YOU, or a family member, have a history of the following conditions?

Heart disease_____ Heart attack_____

High blood pressure_____ High cholesterol_____

Gout_____ Chest pain (angina)_____

Diabetes_____ Asthma or Shortness of Breath_____ Other respiratory or heart condition_____

10. Do you smoke? ___YES ___NO If yes, please describe the type and amount per day:

_____

11. Do you consume alcoholic beverages? ___YES ___NO If yes: ___ daily ___weekly ___occasionally

12. Do you use recreational drugs? ___YES ___NO If yes: ___ daily ___weekly ___occasionally

13. Please describe any past or current musculoskeletal conditions you have incurred

(i.e.: muscle pulls, strains/sprains, fractures, surgery, back pain, or general discomfort).

Head / neck_____ Upper back_____

Shoulder / clavicle_____ Arm / elbow _____

Wrist / hand _____ Lower back _____

Hip / pelvis _____ Thigh / knee_____

Lower leg _____ Ankle / foot_____

14. Are you on a special diet for any reason? ___YES ___NO

Describe: _____

15. Do you take any dietary supplements, multivitamins/herbal-nutraceuticals on a regular basis? ___YES ___NO If yes, please list and for what health benefit? Use the back side of this page if more room is needed:

_____
_____
_____

16. Have you recently experienced any significant weight gain or loss? ___YES ___NO When?_____

17. How many caffeine-containing beverages do you consume in an average day?

_____

18. Do you follow any regular exercise program or sports activity? ___YES ___NO
Describe: _____
_____

19 How would you describe your level of physical activity?

___Sedentary ___Minimal ___Moderate ___Average ___High

20. How would you describe the amount of stress in your daily environment?
___Minimal ___Moderate ___Average ___Extreme

21. Have you ever experienced a loss or any stressful life changing event? ___YES ___NO
Describe/When?
_____
_____

22. Have you ever been a victim of physical or emotional abuse? __YES __NO
If yes, When? _____

23. How would you describe your Sleep? ___ Deep ___ Light ___ Restless
How many hours do you sleep? _____Do you wake up during the night? ___YES ___NO
How do you feel when you wake up? __Alert __ Ready to Go __ Groggy __Tired __Slow starting

24. How would you describe your general mood? (Check all that apply)
___cheerful ____sad ___angry at self ____disgusted ____calm ___guilty ___enthusiastic
___ afraid ___joyful ____downhearted ____tired ____nervous ____lonely ____distressed
____shaky ____happy ____excited ___frightened ____alone ____relaxed ____irritable
____upset ____delighted ____angry ____at ease ____energetic ____scared
____disgusted with self ____dissatisfied with self

History completed by
(signature)_____Date_____

C y m a t h e r a p y[SM] PAIN/PROBLEM DRAWING

Name: _____

Date: _____Time: _____

Directions: on the diagrams below, shade in the areas where you have pain/problem**.**