

## Health History

Are you taking any of the following medications?

Nerve pills    Pain Killers ( including aspirin)    Muscle relaxers    Stimulants  
Blood thinner    Tranquilizers    Insulin    Others

Do you have any of the following diseases or conditions?

Y N Heart Attack/ Stroke	Y N Psychiatric Problems
Y N Heart Surg./ Pacemaker	Y N Kidney
Y N Congenital Heart Defect	Y N Sinus Problem
Y N Mitral Valve Prolepses	Y N Difficulty Breathing
Y N Heart Murmur	Y N Artificial Bones/ Joints
Y N Artificial Valves	Y N Hepatitis
Y N Alcohol/ Drug Abuse	Y N Cancer
Y N HIV/Aids	Y N Anemia
Y N Venereal Disease	Y N Rheumatic Fever
Y N Shingles	Y N Ulcer/ Colitis
Y N Frequent Neck Pain	Y N Asthma
Y N Lower Back Problems	Y N Chemotherapy
Y N High/ Low Blood Pressure	Y N Arthritis
Y N Severe/ Frequent Headaches	Y N Emphysema
Y N Fainting/ Seizures/ Epilepsy	Y N Emphysema
Y N Diabetes/ Tuberculosis	Y N Emphysema
Y N Emphysema	

Weight \_\_\_\_lb.  
Height \_\_\_\_ft. \_\_\_\_in.

Please list anything that you may be allergic to: \_\_\_\_\_

List previous surgeries/ treatments with dates: \_\_\_\_\_

List past serious accidents with dates: \_\_\_\_\_

Family Health History: \_\_\_\_\_

Do you take Supplements or Vitamins? Y N    Exercise? Y N    Special Diet? Y N    Since : \_\_\_/\_\_\_/\_\_\_

Do you smoke? Y N    How Much? \_\_\_\_\_    How Long? \_\_\_\_\_

Are you wearing:  Heel Lifts     Sole Lifts     Inner soles     Arch supports

What is the age of your mattress? \_\_\_\_\_ Is it comfortable? Y N

**For women** : Are you taking Birth Control? Y N    Are you Pregnant? Y N    How long? \_\_\_\_\_    Nursing? Y

- We invite you to discuss with us any questions regarding our service. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made; you will be responsible for legal fees, collection agency fees and any other expenses incurred in collecting you account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_