Melody Craven, L.M.T. - Client Health History Form

Check the following conditions that apply to you, past and present. Please include specific comments to clarify the condition.

Musculo-Skeletal
- o Headaches
- o Joint stiffness/swelling
- o Spasms/cramps
- o Broken/fractured bones
- o Strains/sprains
- o Back, hip pain
- o Shoulder, neck, arm, hand pain
- o Leg, foot pain
- o Chest, ribs, abdominal pain
- o Problems walking
- o Jaw pain/TMJ
- o Tendinitis
- o Bursitis
- o Arthritis
- o Osteoporosis
- o Scoliosis
- o Bone or joint disease
- o Other: _____

Circulatory and Respiratory
- o Dizziness
- o Shortness of breath
- o Fainting
- o Cold feet or hands
- o Cold sweats
- o Swollen ankles
- o Pressure sores
- o Varicose veins
- o Blood clots
- o Stroke
- o Heart condition
- o Allergies
- o Sinus problems
- o Asthma
- o High blood pressure
- o Low blood pressure
- o Lymphedema
- o Other: _____

Skin
- o Rashes
- o Allergies
- o Athlete's Foot
- o Warts
- o Moles
- o Acne
- o Cosmetic surgery
- o Other: _____

Digestive
- o Nervous stomach
- o Indigestion
- o Constipation
- o Intestinal gas/bloating
- o Diarrhea
- o Diverticulitis
- o Irritable bowel syndrome
- o Crohn's Disease
- o Colitis
- o Adaptive aids
- o Other: _____

Nervous System
- o Numbness/tingling
- o Twitching of face
- o Fatigue
- o Chronic pain
- o Sleep disorders
- o Ulcers
- o Paralysis
- o Herpes/shingles
- o Cerebral Palsy
- o Epilepsy
- o Chronic Fatigue Syndrome
- o Multiple Sclerosis
- o Muscular Dystrophy
- o Parkinson's disease
- o Spinal cord injury
- o Other: _____

Reproductive System
- o Pregnancy:
  - o Current
  - o Previous
- o PMS
- o Menopause
- o Pelvic Inflammatory Disease
- o Endometriosis
- o Hysterectomy
- o Fertility concerns
- o Prostate problems

Other
- o Loss of appetite
- o Forgetfulness
- o Confusion
- o Depression
- o Difficulty concentrating
- o Drug use _____
- o Alcohol use _____
- o Nicotine use _____
- o Caffeine use _____
- o Hearing impaired
- o Visually impaired
- o Burning upon urination
- o Bladder infection
- o Eating disorder
- o Diabetes
- o Fibromyalgia
- o Post/Polio Syndrome
- o Cancer
- o Infectious disease (please list) _____
- o Other congenital or acquired disabilities (please list) _____
- o Surgeries _____
- o Other: _____

For clients who need mobility assistance, please give your height: _____ weight: _____

Please list any additional comments regarding your health and well-being: (Use back of sheet if necessary) _____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature:_____Date:_____