MURPHY
THERAPEUTIC GROUP

Health History Form

An accurate health history is important to ensure therapy is safe for you. All information collected is confidential. You will be asked for written authorization for release of any information.

Name: ______________________________ Occupation: ____

Home Tel#: __________________________ Cell#: _________________________ Age: ___________

Home Address:
____

Date of Birth: ______________________ Email: ____

Family Physician Name: ______________________ Primary Complaint:______________________________

Please circle/check any that apply to you.

Cardiovascular

High Blood Pressure Yes ___ No ___
Low Blood Pressure Yes ___ No ___
Heart Condition Yes ___ No ___
Pace Maker Yes ___ No ___
Stroke Yes ___ No ___
Please explain ________________________________

Respiratory

Shortness of breath Yes ___ No ____
Chest Pain Yes ___ No ____
Asthma Yes ___ No ____
Bronchitis Yes ___ No ___
Emphysema Yes ___ No ___

Head / Neck

History of Headache Yes ___ No ___
Altered Taste Yes ___ No ___
Vision Disturbances Yes ___ No ___
Hearing Impairment Yes ___ No ___
Migraines Yes ___ No ___

Other Conditions

Diabetes Yes ___ No ___
Dizziness Yes ___ No ___
Thyroid Dysfunction Yes ___ No ___
Liver Dysfunction Yes ___ No ___
Cancer Yes ___ No ___
Epilepsy Yes ___ No ___
Urinary Dysfunction Yes ___ No ___
Depression Yes ___ No ___
Vomiting/Nausea Yes ___ No ___
Recent Infection Yes ___ No ___
Allergies Yes ___ No ___
Do you take Insulin? Yes ___ No ___
Blackouts Yes ___ No ___
Kidney Dysfunction Yes ___ No ___
Arthritis Yes ___ No ___
Osteoporosis Yes ___ No ___
Skin Condition Yes ___ No ___
Bowel Problem Yes ___ No ___
Anxiety Yes ___ No ___
Fever/Chills/Sweats Yes ___ No ___
Please list ____
____

Please list past surgeries and dates ____
____

Please list any other medical conditions ____
____

Please circle/check any that apply to you.

Infectious Diseases

HIV/AIDS Yes ___ No ___ Tuberculosis Yes ___ No ___
Hepatitis Yes ___ No ___

General Health

Have you had any unexplained weight loss? Yes ___ No ___
Do you have night pain? Yes ___ No ___
Have you ever taken oral steroid medication for more than 2 weeks? (prednisone)
Yes ___ No ___
Do you smoke? How many packs per day? Yes ___ No ___ Packs ___
Do you consume alcoholic beverages? Yes ___ No ___
If yes, how many drinks per day? _______________________
Please list all current medications and dosages: ____
____
____
Do you engage in regular exercise? Yes ___ No ___
What type of exercise? Please include duration and frequency _______________________________________
____
Do you engage in recreational activities? Yes ___ No ___
Please list activities ____
____

Other Health Care

Are you currently receiving any other health care services?
Physiotherapy ___ Massage ___ Chiropractor ___ Other ___

Please tell us what your primary goal of treatment is ____
____

Signature: _____________________________ Date: _________________________________

Thank you for taking the time to answer this questionnaire.

PLEASE DO NOT USE EMAIL TO SEND US CONFIDENTIAL INFORMATION