ALTA PHYSICAL AND COMPLEMENTARY THERAPIES
PATIENT SELF HISTORY

Name: _____ Date: _____

Do you have, or have you had, any of the following?	**CIRCLE**	**YES** OR	**NO**
1. Heart or lung trouble……		YES	NO
2. Family history of heart disease……..		YES	NO
3. High blood pressure…….		YES	NO
4. Allergies…….		YES	NO
If yes, to what? _____			
5. History of back/ neck pain……		YES	NO
6. Are you currently pregnant?		YES	NO
Number of children _____			
7. Do you take birth control pills? ……..		YES	NO
8. Recent weight loss……		YES	NO
9. Diabetes …….....		YES	NO
10. Cancer ……..…		YES	NO
If yes, what type? _____			
11. Colitis or ulcer problems ……		YES	NO
12. Bowel/ bladder problems ……..		YES	NO
13. Arthritis …….		YES	NO
If yes, where? _____			
14. Osteoporosis …….……		YES	NO
15. History of steroid use …….……		YES	NO
16. History of drop attacks (fainting spells) ……..……		YES	NO
17. Epilepsy ……..….		YES	NO
18. Do you have Hepatitis: A B or C (circle one) ……		YES	NO
19. Do you have HIV …… .		YES	NO
20. Do you perceive that you are under any higher than normal stress or pressure at: home?		YES	NO
work?		YES	NO
21. Do you exercise on a regular basis?		YES	NO
If yes: How often? What type?			

_____

_____

22. Please list any other medical problems not listed above:

_____

23. Please list all medications (prescription & non-prescription) you are currently taking:

_____

_____