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 perceive that you are under any higher than normal stress or pressure at: home? YES NO
    work? YES NO
19. Do you exercise on a regular basis? ..... YES NO
    If yes: How often? What type?

_____
_____

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

_____

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

_____
_____

22. **Screening for Future Fall Risk** – Please check the one that applies:

(1100F) In the past year, I have had two or more falls or any fall with an injury. YES NO

(1101F) In the past year, I have had no falls or only one fall without injury. YES NO