

Adult Health History: 13 years and older

Oceana Bodyworks

General Information:

Today's Date: _____

Name: _____ DOB: _____

Address: _____ City, Zip: _____

Phones: Primary: _____ Other: _____

Email: _____ Referred by: _____

Emergency contact name and phone: _____

Doctor's name and phone: _____

Whom do you live with: _____

Occupation: _____ Hobbies: _____

Allergies (*topical and internal*): _____

Current medications and supplements: _____

Nightly amount of sleep: _____ Weekly exercise: _____

Average stress level and causes: _____

Do you smoke: _____ how much: _____ Weekly alcohol consumed: _____

Other alternative therapies you have experienced: _____

Please list your primary reasons for seeking CST: _____

Health History:

For each system listed below please describe current concerns first and past concerns next. Be sure to include any accidents, illnesses, or chronic problems. (In parentheses are examples).

Skeletal/ bones (broken bones, arthritis, osteoporosis, scoliosis, back pain): _____

Muscular, Connective Tissue/ muscles, joints (*sprains, bursitis, disc problems*): _____

Eyes, Ears, Nose, Throat, Mouth (*TMJD, braces, hearing problems, speech, sinus, sore throats*): _____

Are you wearing? contact lenses hearing aids dentures

Respiratory/ lungs (asthma, bronchitis, frequent colds, pneumonia): _____

(please continue on other side)

Circulatory/ heart, arteries, veins, blood (*hypertension, varicose veins, bleeds or bruise easily*): _____

Nervous System/ brain, nerves (*headaches, memory problems, concussions, seizures, ringing in ears, shooting pains, depression*):

Digestive & Elimination/stomach, intestines, bladder (*constipation, irritable bowel, urinary tract infection*): _____

Skin (*rashes, psoriasis, eczema, warts*): _____

Birth History (*what you know about your birth*): _____

Endocrine/pituitary, hypothalamus, reproductive, thyroid (*hyperthyroid, diabetes*):

FOR WOMEN ONLY:

Menstrual & Fertility History (*severe PMS, pregnancy complications, hysterectomy, fibroids*): _____

More details on anything described above or other significant factors (*family history, car accidents*): _____

Patient Signature: _____ Date: _____

Physician signature: _____ Date: _____