HEALTH HISTORY for _____ Date _____

Please list all **medications** and their purpose, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements (or you may provide us with a written list to copy).

_____

_____

_____

_____

Are any of your medications in patch form? Yes No Medication name_____

Allergies: _____

Do you currently have, or have you ever had any of the following?

Heart Disease	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	Seizures	Yes	No
Pace Maker	Yes	No	Asthma or Lung Disease	Yes	No
Infectious Disease	Yes	No	Are you pregnant?	Yes	No
Metal Pins or Implants	Yes	No	Do you smoke?	Yes	No
High Blood Pressure	Yes	No	Allergies	Yes	No
Osteopenia/Osteoporosis	Yes	No	Vertigo	Yes	No
CVA/Stroke	Yes	No	Balance Difficulty	Yes	No
Neurological Disorder	Yes	No	High Cholesterol Levels	Yes	No
Rheumatoid Arthritis	Yes	No			

If you checked yes to any of the above, please provide us with details:

_____

_____

Height_____ Weight_____ (Medical insurances require us to supply this information.)

Please list any major surgeries you have had and the approximate date:

_____

_____

_____

I authorize Elite Therapy & Fitness to discuss my health and treatment with:

Name _____ Relationship _____

Patient Signature _____ Date _____