ADVANCED BODY SOLUTIONS, Inc

Patient: ______________________________ DOB: ______________

Health History

Past Medical History: Please indicate if you have had any of the following

☐Alcoholism	☐Embolism	☐Measles	☐Rheumatic Fever
☐Allergy Shots	☐Emphysema	☐Migraine Headaches	☐Scarlet Fever
☐Anemia	☐Epilepsy	☐Mononucleosis	☐Stroke
☐Appendicitis	☐Glaucoma	☐Multiple Sclerosis	☐Thyroid Problems
☐Arthritis	☐Goiter	☐Mumps	☐Tonsillitis
☐Asthma	☐Gout	☐Osteoporosis	☐Tuberculosis
☐Bleeding Disorders	☐Heart Disease	☐Pacemaker	☐Tumors / Growths
☐Breast Lump	☐Hepatitis	☐Parkinson's Disease	☐Typhoid Fever
☐Bronchitis	☐Hernia	☐Pinched Nerve	☐Ulcers
☐Cancer	☐Herniated Disk	☐Pneumonia	☐Vaginal Infections
☐Cataracts	☐High Blood Pressure	☐Prostate Problems	☐Whooping Cough
☐Chicken Pox	☐High Cholesterol	☐Prosthesis	Other:______________
☐Diabetes	☐Kidney Disease	☐Psychiatric Care	______________
☐ Eating Disorders	☐Liver Disease	☐Rheumatoid Arthritis	______________

Social History: Please indicate any that apply

Daily Exercise	**Work Type**		**Habits**
☐ None	☐ Sitting	☐ Smoking	Packs/Day______________
☐ Light	☐ Standing	☐ Alcohol	Drinks/Week______________
☐ Moderate	☐ Light Labor	☐ Caffeinated Drinks	Cups/Day______________
☐ Heavy	☐ Heavy Labor	☐ High Stress Levels	Reason______________

OB & Pregnancy History:

Number of pregnancies: __________ Number of children: __________ Deliveries by C-Section or Vaginally

Do you currently have an IUD? ◯ Yes ◯ No

Injuries: Have you ever…

◯ had a fracture or broken a bone
◯ used a crutch or other support
◯ been injured in an accident
◯ had a spine or nerve disorder
◯ used a neck or back brace
◯ been knocked unconscious
◯ other: ______________________________

Surgical History: (include date)

◯ Appendix removal __/__
◯ Eye Surgery __/__
◯ Spine: __/__ ______________
◯ Bypass surgery__/__
◯ Hysterectomy__/__
◯ Elective surgery: __/__ ______________
◯ Cosmetic surgery__/__
◯ Pacemaker__/__
◯ Tonsillectomy __/__
◯ Other (Please include date):

____

____

Allergies:______________________________

____

Medications:______________________________

____

Patient Signature:______________________ Date:______________

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