MEDICAL HISTORY

Name:	Date of Birth:

Have you been diagnosed with or have a history of any of the following? Please select all that apply.

o Acute, undiagnosed pain	o Deep vein thrombosis*	o Liver disease*
o Allergies	o Edema or swelling	o Lung disease or infection
o Arterial disease	o Ehlers Danlos syndromes	o Lymphatic disorder
o Arthritis	o Epilepsy or seizure disorder	o Neurological disorder
o Autoimmune disease	o Fibromyalgia	o Numbness or tingling
o Bleeding or clotting disorder*	o Foot pain or disorder	o Osteoporosis
o Botox or facial fillers	o Fracture	o Pulmonary embolism*
o Burn	o Head or brain injury	o Shingles
o Cancer*	o Headaches or migraines	o Sprain or strain
o Chronic fatigue or pain	o Heart attack or disease*	o Stroke
o Concussion	o High blood pressure	o Skin disorder or infection
o Covid or long Covid	o Joint replacements	o Thyroid disorder
o Diabetes	o Kidney disease*	o Tuberculosis
o Digestive disorder	o Lipedema	o Vein disease or infection

Have you had any surgeries or injuries in the past? oYes oNo If yes, please describe.

Have you had any scarring? oYes oNo If yes, please describe.

I use a wheelchair, walker or cane. oYes oNo

Have you had any metal surgically placed in your body (such as after a fracture) or embedded by injury? oYes oNo If yes, please describe.

Have you had any medical implants surgically placed, such as a pacemaker, cochlear implant, glucose monitor, pain pump, port, etc.? oYes oNo If yes, please describe.

Have you had surgical mesh placed in your body after repair of a hernia or prolapse? oYes oNo If yes, please list.

Are you taking any medications currently? oYes oNo If yes, please list.

Do you have a history of chemo or radiation treatments? oYes oNo Have you been vaccinated in the past month? oYes oNo

Please list any allergies.
Do you have an allergy to aspirin? oYes oNo Do you have an allergy to corn starch? oYes oNo

Have you been vaccinated within the past two weeks? oYes oNo

For females: Are you pregnant or believe you may be pregnant? oYes oNo

I understand it is my responsibility to inform the therapist of my medical conditions and understand the importance of disclosing any conditions and medications, as there may be risks based on my physical condition. I have provided an accurate and complete medical history and agree to disclose any changes in my health or medications. I understand that there shall be no liability on the therapist's part should I fail to do so.

By signing this form, I certify that the above information is correct. I certify that I am over the age of 18.

Signature:	Date: