Balanced Bodywork Therapy of Annapolis (BBTOA) – Neuromuscular Therapy

Confidential Patient Medical History/Check-List

Today's Date: _____/_____/_____

Please indicate/check all that apply to the Patient:

How would you rate your overall health?	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
What type(s) of exercise do you do?	☐ Strenuous	☐ Moderate	☐ Light	☐ None	

Please check all of the conditions listed below that historically and currently apply to you.

- ☐ Headaches
- ☐ Migraines
- ☐ Whiplash, Sciatica
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain
- ☐ Frozen Shoulder
- ☐ Elbow/Upper Arm Pain
- ☐ Wrist Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Hand Pain
- ☐ Hip Pain
- ☐ Upper Leg Pain
- ☐ Knee Pain
- ☐ Ankle/Foot Pain
- ☐ Plantar Fasciitis
- ☐ Jaw/TMJ Pain
- ☐ Joint Pain/Stiffness
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Cancer (Location)
- ☐ Tumor Asthma
- ☐ Chronic Sinus Issues
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Chest Pains
- ☐ Stroke
- ☐ Angina
- ☐ Kidney Stones
- ☐ Kidney Disorders
- ☐ Bladder Infection
- ☐ Frequent Urination
- ☐ Loss of Bladder Control
- ☐ Prostate Problems
- ☐ Abnormal Weight Gain/Loss
- ☐ Loss of Appetite
- ☐ Abdominal Pain
- ☐ Ulcer
- ☐ Hepatitis
- ☐ Liver/Gall Bladder Disorders
- ☐ General Fatigue
- ☐ Muscular Incoordination
- ☐ Visual Disturbances
- ☐ Dizziness
- ☐ Diabetes
- ☐ Pregnancy
- ☐ Smoking/Use of Tobacco
- ☐ Drug/Alcohol Dependence
- ☐ Allergies:
  - ☐ Medicine:______________
  - ☐ Other: ________________
- ☐ Depression
- ☐ Systemic Lupus
- ☐ Epilepsy
- ☐ Dermatitis/Eczema/Rash
- ☐ HIV/AIDS
- ☐ Herpes/Shingles
- ☐ Other:

What activities do you do at work/school?

Sit:	☐ Most of the day	☐ Half of the day	☐ A little of the day
Stand:	☐ Most of the day	☐ Half of the day	☐ A little of the day
Computer Work:	☐ Most of the day	☐ Half of the day	☐ A little of the day
On the Phone:	☐ Most of the day	☐ Half of the day	☐ A little of the day

What activities do you do outside of work/school?

____

____

List all prescription and over-the-counter medications you are currently taking.

____

____

List all surgical procedures you have had.

____

____

Have you had a significant past physical trauma?

____

____

Patient Signature: ____