NAME _____ **Age** _____ **Date of Birth**_____

MEDICAL HISTORY ☒ or ☑ **REFERRING DOCTOR/PHYSIO**_____

Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Thyroid disease ☐

Depression/Bi Polar disorder ☐ Asthma ☐ DVT/ Pulmonary embolus ☐

OTHER

DO YOU SUFFER FROM? ☐

Irritable bowel syndrome; Migraines, Fibromyalgia, Chronic fatigue Syndrome, Anxiety, Mood Disorder

HAVE YOU HAD CANCER BEFORE? ☐ **HAVE YOU BEEN HOSPITALISED RECENTLY?** ☐

ARE YOU an injury on duty patient, road accident fund or medico-legal case? ☐

FAMILY HISTORY: Spine, arthritis problems ☐ **:** _____

SURGICAL HISTORY

DATE	PROCEDURE

MEDICATION **ALLERGY**_____

DO YOU USE ANY BLOOD THINNING AGENTS EG PLAVIX, WARFARIN, ASPIRIN? ☐

SMOKING? ☐ No. of Cigarettes/day ☐ No. of years you have smoked ☐

ALCOHOL? : Units per week ☐ **SOCIAL:** Married /Single:_____Children_____

EMPLOYED? : ☐ Physical ☐ or sedentary job ☐ _____

DO YOU EXERCISE? ☐ If so what and how many times per week:

Would you describe your health as good? ☐ Have you had any of the following symptoms recently ? ☐

Night sweats; Unexplained Loss of weight; Chronic cough; fevers; Change in bowl habit ; Other painful joints