Medical History

Client's *(Surname)*	*(First Name)*	*(Initial)*	Date of Birth *(Year / Month / Day)*
Address *Street*		*City/Town*	*State / Province*
Zip / Postal Code	Telephone Number	Date of Service *(Year / Month / Day)*	

Medication History:

Date prescribed	Medication	Dose	Frequency

General Health:

- ☐ Heart problems
- ☐ High blood pressure
- ☐ Pacemaker
- ☐ Allergies
- ☐ Headaches
- ☐ Head trauma
- ☐ Strokes
- ☐ Diabetes
- ☐ Tobacco use

Other conditions:

Summary/Comments:

Assessment completed by: