SBR Therapy and Wellness
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GENERAL HEALTH FORM

Patient Information:

Patient Name: Date:

Address:

Occupation/ Previous if Retired:

Email: ______________________________ Gender: M / F / T

DOB: _________________

Phone: Cell ______________________ Work __________________________

Emergency contact: _______________________ Phone __________________

Medical Doctor: _______________________ Phone ____________ FAX: ________________

Referred to Office by:

____

Current Health Report:

Please describe the principle problems for which you came to this office for:

1. ____
2. ____
3. ____

Are your present complaints due to an injury? Y N Auto Accident Work accident

Any Past services for your complaints? Therapy, chiropractor, physician, massage, acupuncture, trainer

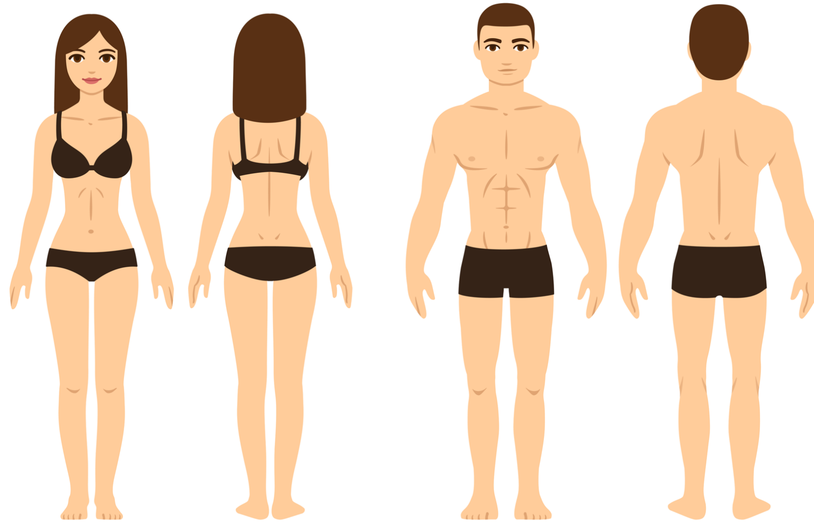
Self Reported Medical History Form:

PLEASE CIRCLE ANY CURRENT COMPLAINTS

Anemia	Digestive Problems	Night pain/sweats
Ankle Swelling	Dizziness/Fainting	Numbness/tingling
Anorexia/Bulimia	Epilepsy/Seizures	Osteoporosis
Arthritis	Falls, trips, slips	Ovarian cancer
Bladder Infection	Heart problems	Pudendal nerve irritation
Breast Cancer	Headaches/migraines	Prostate cancer
BPH (enlarged Prostate)	High Blood Pressure	Prostatitis
Breathing Difficulty	Hyper or hypo thyroid	Sexually transmitted disease
Chronic Fatigue/fibromyalgia	Hepetitis/ HIV	Smoking history/currently
Depression	Kidney disease	Stroke
Diabetes	Low back pain	Tailbone bone/sacrum pain
Other:	lightheadedness	Vision/hearing problems
Other:	Other:	Weight gain / loss

Please identify sites of pain and note types below:

N = numbness P = pain T = tingling A = ache S = soreness ST = stiffness



Imaging taken:

____

Therapy, chiropractic or acupuncture in past/current:

____

Medication / supplement List: (please include name, dose, and reason for taking):

____

Surgeries: (please include year)

____

Do you have any allergies? Please list

____

Patient Signature: ____ Date:____________