Breakthrough Health – Health History Update

Name:_____ Date:_____

Circle One

1. Has there been any changes in your health or medical history since your last visit? YES NO

   What?_____

2. Are you currently taking any medication? YES NO

   What?_____

3. Has there been any injury to head, neck or back since your last visit? YES NO

   What?_____

4. Is there any condition or problem you wish to bring to the therapist's attention this visit? YES NO

   What?_____

Client Record Update

5. Is there a change in your address or phone number? YES NO

   What?_____

6. Is there a change in your work address or phone number? YES NO

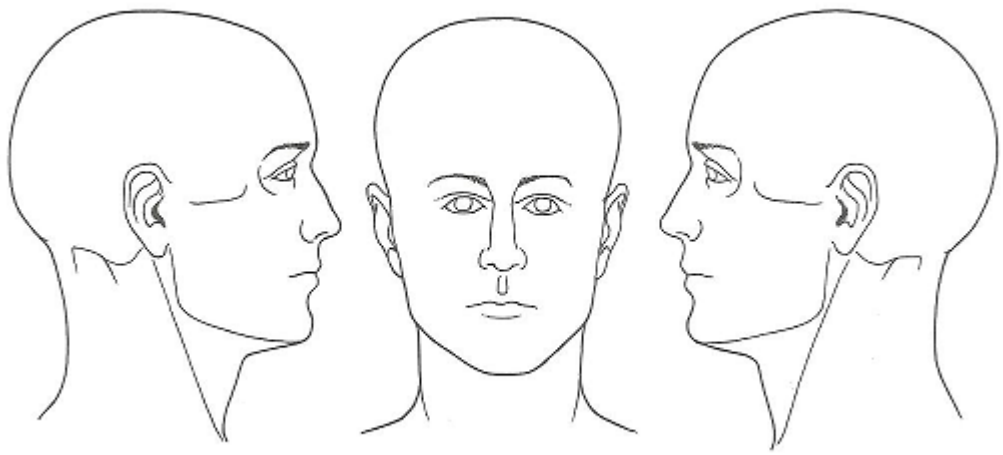
   What_____

Additional Comments:

_____

_____

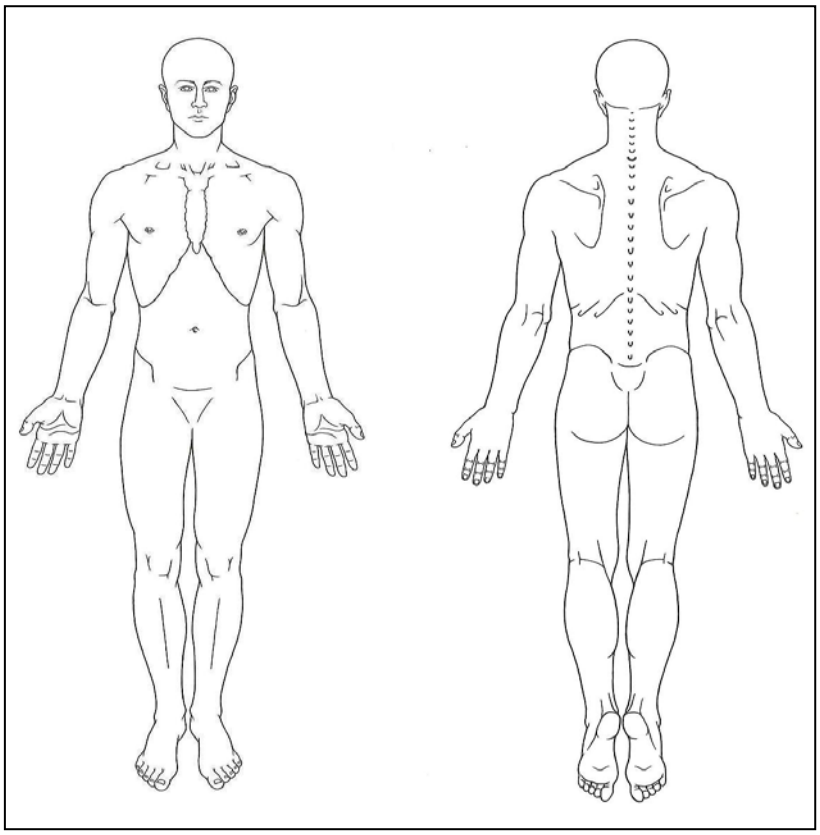
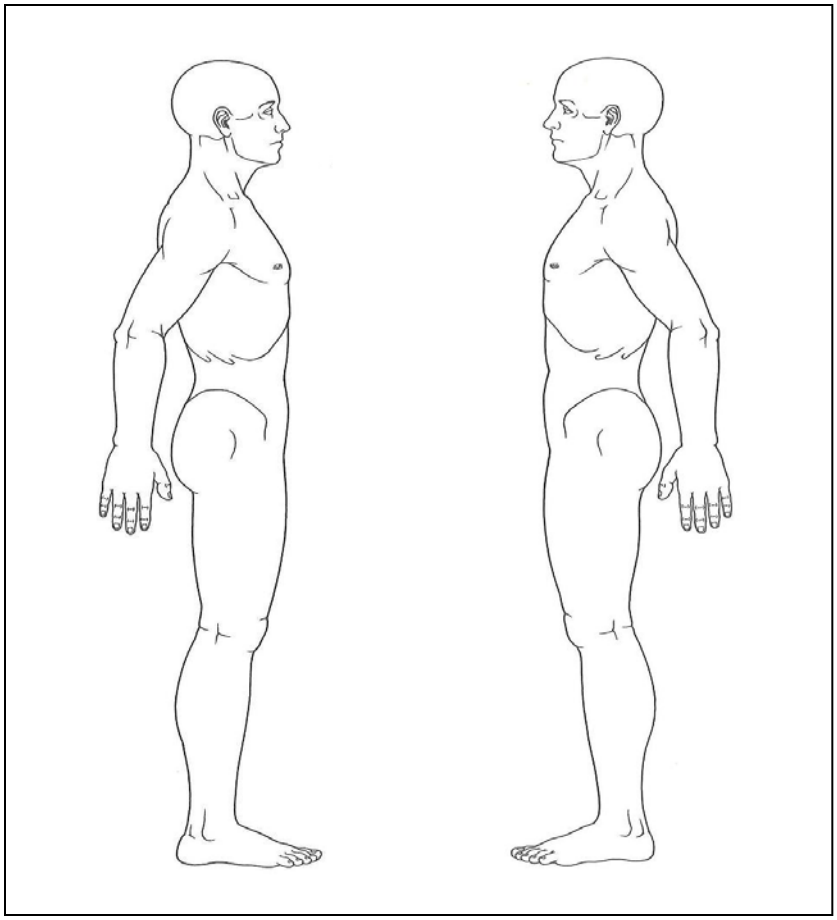
Head/Neck



Place an "X" to indicate location of pain or discomfort

Place an "X" to indicate location of pain or discomfort

Front/Back of Body



Right/Left Side of Body