Nationally Certified, Tennessee License # 132
Marty Austin, Ms

220 South Peters Road
Suite 102
Knoxville, TN 37923

Medical History

Certified Russian Rehabilitative
Neuromuscular,
Pregnancy .Infancy,
Manual lymphatic Drainage/
Complete Decongestive Therapy
CranioSacral Therapy

We understand that this information is personal and confidential

Name_____Address_____City_____State_____
Home Phone# ( )_____Cell Phone#( )_____AGE_____M/F_____
Married_____ Single_____ Divorced_____ Occupation _____
Email:_____@_____
Known Birth Problems: _____Referred by_____
Present Symptoms (your major complaint):_____
_____
_____
_____
When did you first notice major complaint?_____
Minor complaints (other areas of pain or concern);_____
_____
What brought it on?_____
What activities aggravate the condition_____
_____
Is this condition getting progressively worse?_____
Is this condition interfering with your work? _____Sleep? _____daily routine?
_____
What do you believe is wrong with you?_____
What have you done to get relief?_____
Has there been a medical diagnosis? _____By whom?_____
X-Rays? _____M.R.I_____

Past History:
Have you had similar problems before? _____If yes, explain: When?_____
What caused the episodes? _____What relieved them?_____
Did they prevent you from working? _____ Hospitalize you? _____Disable you?_____
What was the previous diagnosis?_____
What were the treatments?_____
Did they help?_____
Name of the attending physician?_____
Are you on any medication?_____List:_____
_____

How many physicians have treated you for this injury?_____

Are you taking any of the following? Circle all that apply:

Laxatives	Sedatives	Aspirins	Vitamins	Anti-Depressants
Sleeping Pills	Hormones	Insulin	Herbs	Diet supplements

Social Habits:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee/Tea/Caffeine	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Weekly sugar intake	_____	_____	_____	_____

(Confidential Case History---Continued)

Have you ever:	Yes	No	Describe briefly
Had any operations?	_____	_____	_____
Broken any Bones?	_____	_____	_____
Been in Auto Accident?	_____	_____	_____
Had whiplash?	_____	_____	_____

Other:
How many Bowel movements daily? _____Do you have a history of constipation?_____
If yes, what have you done to relieve it?_____
Age of Bed Matteress?_____Comfortable?_____Uncomfortable:_____Bed board_____
Do you use a foam pillow?_____
Do you sleep on your: Side?_____Back?_____Stomach?_____
Do you wear: Heel lifts? _____Sole lifts?_____ Arch supports? _____Inner soles?_____
Which hand is your dominant hand? Left_____ Right_____
Which pocket do you carry a wallet in? Left_____ Right_____
Which shoulder do you carry your purse on? Left_____ Right_____

Do you have any difficulty with the following/ Circle all that apply.

Headaches	Light bother eyes	Cold sweats
Shooting head pains	Irritability	Liver trouble
Sinus trouble	Muscle spasms in neck	Gall bladder trouble
Loss of smell	Grating in neck	Indigestion
Hay fever	Tightness of shoulder muscles	Intestinal gas
Asthma	Neuritis in shoulders and arms	Constipation
Loss of taste	Pins and needles in arms and hands	Kidney trouble
Tightness in throat	Cold hands	Bladder trouble
Thyroid trouble	Chest pains	Diabetes
Face flushed	Shortness of breath	Cancer
Twitching of face	Tuberculosis(T.B)	Sleeping problems
Loss of memory	Heart pain	Painful joints
Fatigue	Heart palpitations	Swollen joints
Depression	Heart attack	Arthritis
Head feels too heavy	High blood pressure	Pinched nerves
Dizziness	Low blood pressure	Pins and needles in legs
Fainting	Anemia	Swollen ankles
Loss of balance	Rheumatic Fever	Cold feet
Ringing in ears	Nervous stomach	Pains in legs and feet
Wearing glasses	Ulcers	Disc herniation
Nerves and nervousness	Inner tension	Disc rupture
		Slipped disc/bulging/Disc rupture

Male Only:		**Female only:**	
	Pain in groin		Menopausal hot flashes etc
	Sacroiliac or low back pain		Melancholia of long standing
History of prostrate trouble	Tire easily	Very easily fatigued	I.U.D. Diaphragm
Frequent night urination	Lack of energy	Premenstrual tension, depression	Number of pregnancies___
Urination difficult or dribbling	nervousness	Painful menstruation cramps	Birth control pill
Burning upon urination	Excessive perspiration	Menstruation excessive or prolonged	Breast implants
Pain in the shoulders	Dizziness	Menstruation scanty or missing	Hysterectomy
Persistent abdominal pain	Diminished sex drive	Vaginal discharge	Births
Pain on outside of legs and heels	Burning or pain during orgasm	Painful breasts	Difficult births or pregnancies

When I need to reschedule or cancel my appointment, I agree to notify you at least twenty-four (24) hours in advance. If I miss an appointment without giving notice, I will respect my commitment with full payment.

SIGNATURE;_____DATE:_____

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