Health History Questionnaire - Cupping and Manual Therapy

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Have you received any of the COVID-19 Vaccines? If Yes, please present vaccination card at first appointment for verification.

- [ ] No
- [ ] 1st Shot
- [ ] 2nd Shot (less than 2 weeks ago)
- [ ] Fully Vaccinated (more than 2 weeks from last required shot)

Preferred Pronoun(s)

- [ ] she/her/hers
- [ ] he/him/his
- [ ] they/them/theirs
- [ ] Other

If Other, please provide appropriate answer

Aggravating Factors (worse with)

Relieving Factors (better with)

Primary Complaint *

Secondary Complaint

Hospitalizations, Operations, Significant Traumas

Current State of Health

My Body Temperature Feels?

- [ ] Hot
- [ ] Cold
- [ ] Comfortable

General Symptoms

- [ ] Edema
- [ ] Bruise Easily
- [ ] Chills
- [ ] Aversion to Cold
- [ ] Body Aches
- [ ] Aversion to Wind
- [ ] Low Thirst
- [ ] Aversion to Heat
- [ ] Strong Thirst
- [ ] Insomnia
- [ ] Poor Appetite
- [ ] Night Sweats

- [ ] Fever
- [ ] Foggy-headed
- [ ] TMJ
- [ ] Headaches
- [ ] Migraines
- [ ] Poor Digestion
- [ ] Fatigue
- [ ] Dizziness
- [ ] Eye Strain
- [ ] Concussion
- [ ] Sweats Easily
- [ ] Nasal Congestion
- [ ] Shortness of Breath
- [ ] Chest Tightness

Musculoskeletal

What Areas are Painful?

Left-Sided ONLY	BOTH Sides	Right-Sided ONLY
Head	Head	Head
Neck	Neck	Neck
Shoulder	Shoulder	Shoulder
Upper Back	Upper Back	Upper Back
Middle Back	Middle Back	Middle Back
Lower Back	Lower Back	Lower Back
Ribs	Ribs	Ribs
Elbow	Elbow	Elbow
Wrist	Wrist	Wrist
Hand/fingers	Hand/Fingers	Hand/Fingers
Hip	Hip	Hip
Knee	Knee	Knee
Ankle	Ankle	Ankle
Foot/Toes	Foot/Toes	Foot/Toes
Muscle Tightness	Muscle Tightness	Muscle Tightness
General Muscle Weaknes s	General Muscle Weaknes s	General Muscle Weaknes s
Numbness/Tingling	Numbness/Tingling	Numbness/Tingling

Other Areas of Concern