



TAVO Total Health, LLC
4701 Willard Ave, Ste. 1603
Chevy Chase, MD 20815
Phone: (301) 652-2522
Fax: (301) 652-2722
Website: www.tavototalhealth.com

Medical History Disclosure Form

Name: _____ Age & Date of Birth: _____

What areas of the body (ie-neck, L hip, R knee, etc) or conditions (ie, fibromyalgia, osteoarthritis, etc) are you currently seeking physical therapy treatment for?

If there are multiple areas of involvement, which region/problem is of greatest concern at this time?

Have you ever been treated for this same problem before?

If so, when & who treated this problem (ie, 1999 by John Smith, DC & Jane Jones, MSPT)?

Did prior treatment successfully manage or resolve the problem at that time?

Please circle any/all illnesses you've either had in the past or currently have:

Cardiovascular disease	Asthma/Breathing difficulty	Hepatitis/Liver disease	Depression
High Blood Pressure	Congestive Heart Failure	Epilepsy/Seizures	Anemia
Diabetes (I or II)	Multiple Sclerosis	Thyroid condition	Osteoporosis
Stroke or Heart Attack	Fibromyalgia	Neurological condition	Chronic infections
Arthritis (Osteo/Rheum)	Migraines/Headaches	Eating disorder	Lupus
Kidney/Renal disease	Dizzy/Vertigo	Drug or Alcohol abuse	HIV/AIDS
Cancer (Type _____; Location(s) _____; Year _____ Status _____)			

Other: _____

Do you have a pacemaker, internal defibrillator, insulin pump, metal fixator, or any other implanted medical device?

Please list all prescription medications you are presently taking & reason for medication (ie, Prozac for Depression, Percocet for pain, Accupril for High Blood Pressure):

Are you currently pregnant or is there even a possibility you may be pregnant?

What type of exercise and/or sports, if any, do you perform or participate in?

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE & TRUE. IF MY MEDICAL/HEALTH STATUS CHANGES I WILL INFORM YOU IMMEDIATELY.

Signature & Date: _____



TAVO Total Health, LLC

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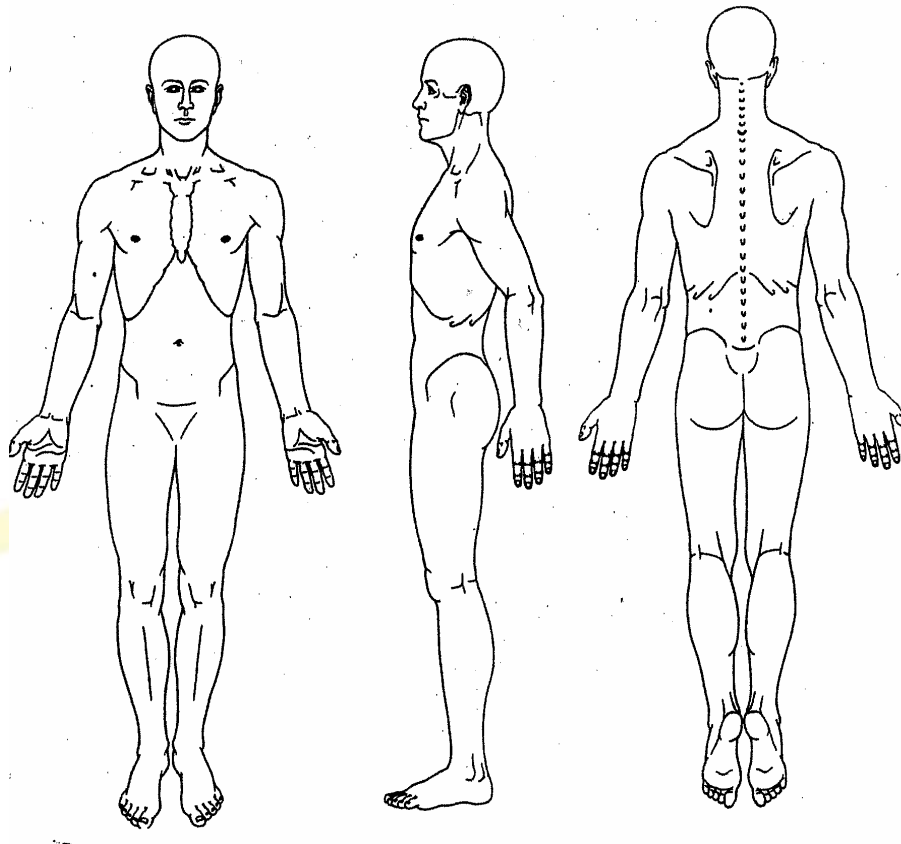
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Please mark the drawings with the following letters to indicate areas of pain (P), numbness (N), tingling (T), or weakness (W):



Please rate your pain using this scale. Also, please indicate which area(s) of your body the score(s) applies to: (0=No pain, 10=Emergency Room pain)

0-----10