



**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 Mattress? \_\_\_\_\_ 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

<b>Male Only:</b>	Pain in groin	<b>Female only:</b>	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:*** \_\_\_\_\_

\_\_\_\_\_