# New CST Patient Form

Today's Date_________________ Name_____________________________________

Address __________________________________________________________________

__________________________________________________________________________

Home Phone_____________________ Cell / Mobile 'Phone_____________________

Work Phone_____________________ Email _________________________________

Age _______________ Physician / GP ________________________________________

**HEALTH HISTORY**

Do you smoke? ____________ How much?_________________________________

Do you have any injuries or orthopedic problems (bursitis, bad back, bad knees, etc.)?

__________________________________________________________________________

__________________________________________________________________________

Which prescribed medications or dietary supplements are you taking? ________________

__________________________________________________________________________

Date of last physical exam / Check-Up _____________________

Do you have any other medical conditions or problems not previously mentioned? _____

__________________________________________________________________________

What are your goals?

__________________________________________________________________________

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*Please circle Yes or No to each of the following questions.* *If Yes, For How Long*

| | | |
|---|---|---|
| Anxiety? Depression? | Yes / No | ___________ |
| Fatigue? | Yes / No | ___________ |
| Migraines or headaches? | Yes / No | ___________ |
| Swollen stiff or painful joints? | Yes / No | ___________ |
| Back problems? | Yes / No | ___________ |
| Have you been told you have a haemorrhage or aneurysm? | Yes / No | ___________ |
| Have you had a concussion in the past few days? | Yes / No | |