Health History Form

Accurate health history is important to ensure that it is safe for you to receive an effective treatment. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate your treatment. You will be asked to provide a written authorization for release of any information.

Name: _____

Address: _____

City: _____ Province: _____PostalCode: _____

Phone (H): _____ (Bus.): _____ (Cell)_____

E-mail: _____

Sex: _____ Gender: _____ Date of Birth: _____

Occupation: _____ Employed By: _____

Marital Status: _____ Number of children: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Name of Medical Doctor: _____Address: _____

How did you hear about us? ❒ Doctor ❒ Massage Therapist ❒ Website ❒ Friends ❒ Family ❒ Other: _____

Address of referring health practitioner: _____

Are you currently receiving other health care for your main health concern? Yes / No If yes, please specify:

_____

_____

Health Concerns

What are your main health concerns in order of importance to you?

_____

_____

Prescription Drugs

List all prescription drugs that you are currently taking. Indicate what the prescription is for and how long you have been on each medication

_____

_____

Medical History

List any surgery's and when they occurred:

_____

_____

List any fractures and when they occurred:

_____

_____

List any major accidents and when they occurred (including car accidents):

_____

_____

Have you ever been knocked unconscious or taken a significant blow to the head? Please circle:

Yes / No If Yes, please state when: _____

Please list any allergies that you have:

_____

_____

Visual Pain Rating Scale

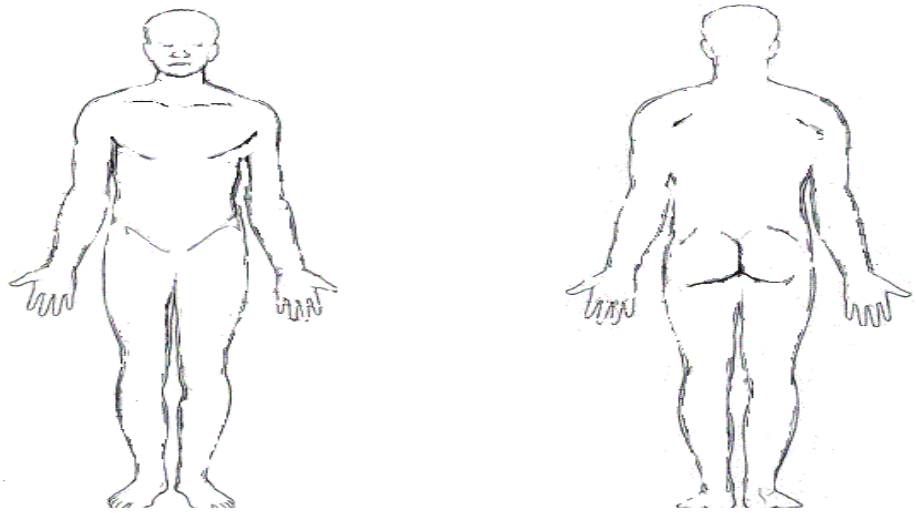
Make a mark (/) along the line which you think represents your current level of pain

No pain at all _____ As bad as it could be

Pain Diagram

On the following diagrams, indicate all areas of:

Pain – xxxx Stiness - //// Numbness - 0000 Other (Specify)- _____



Medical History

In the lists below, check all the areas you are currently experiencing, and place a 'P' in the box of areas you have experienced in the past.

Please list if you have any artificial joints, pins, pacemakers, etc...:

_____

General Conditions

- ☐ Loss of Consciousness
- ☐ Blackouts
- ☐ Headaches
- ☐ Migraines
- ☐ Fever sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions / Seizures
- ☐ Loss of sleep
- ☐ Insomnia
- ☐ Chronic Fatigue
- ☐ Numbness, pain or tingling
- ☐ Nervousness / Anxiety
- ☐ Depression
- ☐ Loss of weight
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Hepatitis A / B / C
- ☐ Edema
- ☐ HIV Positive
- ☐ AIDS
- ☐ Cancer

Muscle and Joints

- ☐ Neck pain
- ☐ Upper back pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Elbow pain
- ☐ Wrist pain
- ☐ Hand pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle pain
- ☐ Foot pain
- ☐ Jaw pain
- ☐ Arthritis
- ☐ Family History of Arthritis

Eyes / Ears / Nose / Throat

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye pain
- ☐ Earache
- ☐ Loss of hearing
- ☐ Ringing / buzzing in ears
- ☐ Frequent colds / infections
- ☐ Enlarged glands / thyroid
- ☐ Speech problems
- ☐ Difficulty swallowing

Respiratory

- ☐ Asthma
- ☐ Allergies
- ☐ Sinus problems
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pleurisy

Cardiovascular

- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Heart attack/myocardial infarction
- ☐ Anemia
- ☐ Stroke/cerebrovascular accident
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Angina
- ☐ Hemophilia / bleeding disorder
- ☐ Circulation problems
- ☐ Varicose veins
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation

Skin

- ☐ Rashes
- ☐ Itching
- ☐ Bruise easily
- ☐ Dryness
- ☐ Boils
- ☐ Hives (allergy)
- ☐ Eczema
- ☐ Psoriasis

Gastrointestinal

- ☐ Poor appetite
- ☐ Indigestion
- ☐ Ulcers
- ☐ Excessive hunger
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Gall bladder problems
- ☐ Irritable bowel syndrome
- ☐ Colitis
- ☐ Crohns disease
- ☐ Celiac disease
- ☐ Hiatus hernia

Genitourinary

- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Prostate trouble
- ☐ Urinary tract infection

Female

- ☐ Painful menstruation / cramps
- ☐ Excessive flow
- ☐ Irregular cycle
- ☐ Hot ashes
- ☐ Vaginal discharge
- ☐ Painful intercourse

Menopausal Y N
Pregnant Y N

Number of:

- pregnancies _____
- abortions _____
- miscarriages _____
- births _____

Male

- ☐ Prostate problem
- ☐ Impotence
- ☐ Pain
- ☐ Infertility/low sperm count
- ☐ STD
- ☐ Hernia

Agreement

I agree that it is my choice to receive manual treatment. I understand that during the treatment the therapist will be open to any questions about procedure or effects as they occur. I understand that the whole external body excluding private areas may be treated. I agree to communicate with my therapist at any time if I feel like my well-being is being compromised.

I understand that manual therapists do not diagnose illness, disease or any physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals. I acknowledge that manual therapy is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the therapist of any changes in my health status. I understand that this treatment is not covered by OHIP. The therapist is not responsible for any billing or dealings with private health insurance companies. However the receipt describing the details of the treatment as well as the therapist registration number will be issued.

Please read and initial that you have read the following:

I understand that I will be charged full price for missed appointments, appointment modifications or cancelled appointments if I do not provide at least 24 hour s advanced notice. Please initial here to show you have read and understood this billing agreement. Initials: _____

Signature

I attest that I have read the above information and that the information provided in this form is true and accurate to the best of my knowledge.

Signature: _____ Date: _____