Adult Health History Form (16 years and older)

An accurate health history is important to ensure it is safe to receive treatment. If your health status changes in the future, please inform your practitioner. All information gathered is confidential except as required by law. You will be asked to provide written authorization for release of any information.

NAME:	DATE OF BIRTH: (mm / dd / yyyy)
PREFERRED NAME (if different from above):	PRONOUNS:
FULL ADDRESS:	
MAIN PHONE #:	EMAIL ADDRESS:
OCCUPATION:	
EMERGENCT CONTACT NAME:	PHONE #:
RELATIONSHIP:	

PRIMARY CARE PHYSICIAN:	PHONE (if known):
CLINIC NAME:	LAST PHYSICAL EXAM: (mm / dd / yyyy)
FINDINGS (if any):	
HAVE YOU HAD X-RAYS OR OTHER IMAGING IN THE LAST 2 YEARS?	
IF YES, WHAT PART OF YOUR BODY?	

Are you seeking treatment associated with an insurance claim?	▫ **Yes** ▫ **No**
If yes, please specify:	

Are you currently seeing any other complementary healthcare providers? ▫ **Yes** ▫ **No**						
Acupuncturist	▢	Massage Therapist	▢	Osteopathic Manual Therapist	▢	Other:
Chiropractor	▢	Naturopath	▢	Physiotherapist	▢	

Please indicate areas of concern and treatment goals.

Have you sustained any significant physical injuries, surgeries, or other medical procedures? If yes, please describe the nature with approximate dates.

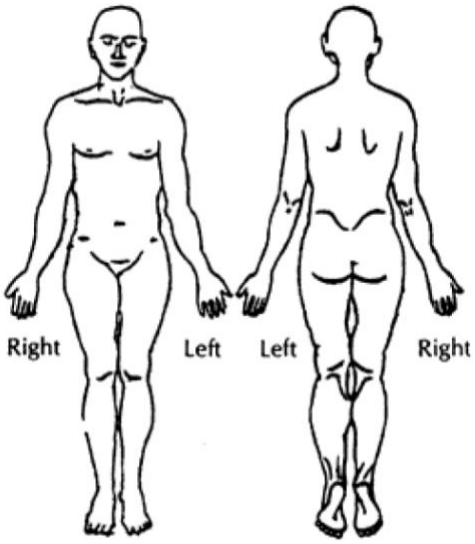
Please list any allergies or sensitivities.

Are you currently taking any medications including over the counter, prescribed or unprescribed drugs, herbs, vitamins? (Including cannabis products, alcohol, caffeine, etc.)

Do you have an infectious disease? (hepatitis, herpes, HIV/AIDS, TB, skin conditions, etc.)	▢ **Yes** ▢ **No**
If yes, please specify:	

Do you wear or have:							
Glasses/Contacts	▢	Hearing aids	▢	Dentures	▢	Other:	▢
Pins/Plates/Screws	▢	Pacemaker	▢	Implants	▢		

In relation to pain / musculoskeletal conditions:	
When did the pain or problem start?	
Does the feeling radiate and where?	
What is the frequency? ▢ Constant ▢ Daily ▢ Weekly ▢ Interferes with sleep	
What time of day is the worse? ▢ AM ▢ PM	Grade the sensation: _____ / 10
What relieves the sensation?	What aggravates the sensation?

Please check all that apply relating to pain, and circle areas of concern on the figure to the right.				
Achy	▢	Shooting	▢	
Burning	▢	Sore	▢	
Gripping	▢	Throbbing	▢	
Numb	▢	Weakness	▢	
Sharp	▢	Change in sensation	▢	
Soft tissue and joint issues: (please check all that apply)				
Cramps/Spasm	▢	Arthritis	▢	
Bursitis	▢	Osteoarthritis	▢	
Inflammation	▢	Osteoporosis	▢	
Sprains/Strains	▢	Paralysis	▢	
Sciatica	▢	Rheumatism	▢	
Swelling	▢	Scoliosis	▢	Other:

Respiratory conditions: (please check all that apply)							
Asthma	▢	Chronic congestion	▢	Chronic sinusitis	▢	Emphysema	▢
Bronchitis	▢	Chronic cough	▢	Cough with phlegm	▢	Shortness of breath	▢
Other:							

Skin conditions: (please check all that apply)							
Acne	☐	Dry skin	☐	Itchy Skin	☐	Shingles	☐
Allergies/Hives	☐	Eczema	☐	Psoriasis	☐	Warts	☐
Bruise easily	☐	Fungal infections	☐	Rashes	☐	Other:	☐

Gastrointestinal conditions: (please check all that apply)							
Acid reflux/Indigestion	☐	Constipation	☐	Gallbladder	☐	Nausea	☐
Bloating/Gas	☐	Crohn's	☐	GERD	☐	Ulcer	☐
Colitis	☐	Diarrhea	☐	IBS	☐	Vomiting	☐

Cardiovascular conditions: (please check all that apply)									
Angina	☐	Blood clots	☐	Heart condition	☐	High blood pressure	☐	Palpitations	☐
Arteriosclerosis	☐	Haemophilia	☐	High cholesterol	☐	Low blood pressure	☐	Varicose veins	☐

Do you have trouble sleeping?	☐ **Yes** ☐ **No**
If yes, please specify:	

Other: (please check all that apply)									
ADHD	☐	Diabetes	☐	Excess perspiration	☐	Hot flashes	☐	Poor appetite	☐
Anxiety	☐	Dizziness	☐	Fainting	☐	Hypoglycaemia	☐	Poor memory	☐
Bell's Palsy	☐	Drug withdrawal	☐	Fatigue	☐	Immunosuppression	☐	Recent injection	☐
Blurred vision	☐	Easily chilled	☐	Headaches	☐	Irritability	☐	Seizures/Epilepsy	☐
Cancer	☐	Edema	☐	Hearing loss	☐	Kidney disease	☐	Stroke	☐
Depression	☐	Excessive appetite	☐	Heart attack	☐	Liver disease	☐	Other:	☐

Do you have any other medical conditions not listed here?	☐ **Yes** ☐ **No**
If yes, please specify:	

Describe any concerns you have regarding your comfort and safety during an acupuncture treatment, such as needle phobia, bleeding disorders (e.g., haemophilia), pacemaker, medication pump, blood pressure, infections, immunocompromised:

Women:			
Do you use birth control pills?	☐ Yes ☐ No	If yes what brand?	
Length of menstral cycle:		PMS (headaches/bloating/cramps etc.)	☐ Yes ☐ No
Have you ever been pregnant?	☐ Yes ☐ No	Are you pregnant or trying to conceive?	☐ Yes ☐ No
Number of pregnancies:		Problems in pregnancy/delivery?	☐ Yes ☐ No
Other relevant information:			

YOUR RESPONSIBILITIES AS A CLIENT

- **Cancelling your appointment**
  We require a 24-hour notice when cancelling or rebooking appointments, this allows other clients to possibly receive care in your place. If an appointment is missed or cancelled within 24 hours, you may be billed.

- **Conduct in the clinic**
  Our clinic is a healing environment. As such, we ask that cell phones and other devices are silenced while in the clinic. We would like to kindly remind you that some people may have allergies or sensitivities to fragrances. Please refrain from using scented products such as perfumes, colognes, and lotions when visiting the clinic.

WAIVER OF RESPONSIBILITY

I understand that treatments are not a replacement for care provided by a medical doctor or mental health professional.

I am aware that treatments may include but are not limited to: Osteopathic Manual Therapy, Massage, CranioSacral Therapy, Acupuncture, Acupressure, Cupping, Gua Sha, Reiki, exercise, the use of electrical modalities.

I understand the therapist is open to any questions throughout the treatment and that they believe in an open discussion concerning the effects and procedures of therapy. I will inform the practitioner of any specific issues related to being touched. I understand that I will be asked for additional consent for some specific techniques, if we have decided that those treatments will be beneficial to my wellbeing, and if I am comfortable doing so.

I consent to treatment and have provided a complete and accurate health history. I understand that this form will remain valid, and in effect for the duration of my care.

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. I understand that my personal and medical information is confidential and will only be disclosed to third parties with written permission.

Please Note:
Payment is due at time of treatment. We do not direct bill. Treatments are not covered by Alberta Health Care but may be covered by private insurance. Missed appointments may be billed at the full rate unless 24 hours' notice is provided. Please be aware that insurance companies do not reimburse for missed appointments.

Name: (please print) _____

Signature : _____

Date: (mm **/** dd **/** yyyy **)**