

Health History Form

Name: _____

Address: _____

(city) _____ (postal code) _____

Phone number (home): _____ (work) _____ e-mail _____

Date of Birth _____ Occupation _____

Emergency Contact (name / phone numbers): _____

Primary Care Physician: _____

Address: _____

Telephone: _____

Last Physical Exam: _____ Findings: _____

Have you had X-rays during the past 2 years? Yes No If Yes, what part of your body? _____

Present involvement in other healthcare: Yes No
Type of Provider: chiropractic physiotherapy acupuncture other

Family history: arthritis cancer diabetes heart disease spinal problems stroke
 mental disease allergies other _____

Personal History:

Childhood diseases: measles mumps chickenpox other childhood diseases _____

Current medications: _____

Condition(s) treated: _____

Surgery/hospitalization: _____

Nature: _____

Date(s): _____

Injury (please specify): _____

Nature: _____

Date(s): _____

Health History Form

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required by law or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

Please indicate conditions you are experiencing, or have experienced. Indicate those you currently have with a checkmark "✓", and those you have had with an "x".

Respiratory :

- chronic cough
- shortness of breath
- bronchitis
- asthma
- emphysema
- difficulties breathing
- other _____

Skin:

- skin conditions
- dry skin
- eczema
- other _____

Infections:

- hepatitis
- skin conditions
- TB (Tuberculosis)
- HIV
- other _____

Cardiovascular:

- high blood pressure
- low blood pressure
- CCHF (chronic congestive heart failure)
- heart attack. How long ago _____
- heart disease. Type _____
- phlebitis
- stroke
- pacemaker or similar devise
- hemophilia
- other _____

Other conditions:

- diabetes (onset: _____)
- hypoglycemia
- hyperglycemia
- allergies - food
- allergies - environmental
- cancer. Type _____
- arthritis. Type _____
- blurred vision
- epilepsy
- vision loss
- ear problems
- hearing loss
- headaches

Soft tissue / joint discomfort and its nature:

- neck _____
- low back _____
- upper back _____
- shoulders _____
- arms/hands _____
- legs _____
- knees _____
- feet _____
- other _____
- loss of sensation

Women

- pregnant (due: _____)
- length of menstrual cycle _____ days
- PMS (headaches, bloating, cramping, etc)
- currently using oral contraception

- glasses / contact lenses
- other _____

Other:

- chill easily
- chronic problems
- contagious disorder
- current injury
- dentures
- depression
- disorder of an organ
- loose stools
- sexual dysfunction
- poor appetite
- night sweats
- flu / cold
- nervousness
- osteoporosis
- pins / plates / screws
- immunosuppression
- injection (recent)
- excessive gassiness
- excessive perspiration
- excessive appetite
- hot flashes
- nerve pain / inflammation
- spinal disorder
- swelling / edema
- syncope (fainting)
- previous hospitalization
- previous injuries
- insomnia
- palpitations of the chest
- learning disabilities
- drug withdrawal
- fatigue
- dizziness
- varicose veins
- indigestion
- heartburn
- lump in the throat
- poor memory
- constipation
- chemical sensitivities

Sport Injury When: _____ Type of Injury: _____

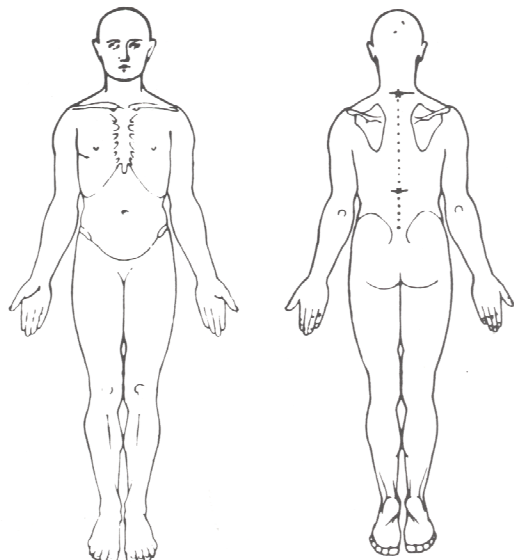
Motor vehicle accident When: _____ Type of Injury: _____

none of the above other _____

Health History Form

Main complaint: (Onset- How-Progression-Location) _____

Locate the pain:



Describe the pain:

- aches
- dull
- numbness
- shooting
- stabbing
- tingling
- burning
- gripping
- sharp
- sore
- throbbing
- weak

other _____

Grade the pain: Low 1 2 3 4 5 6 7 8 9 10 High.

Pain Worse at What Time: AM PM

Frequency of pain: constant daily weekly monthly acute chronic interferes with sleep

Does the pain radiate: yes no Where? _____

What relieves your condition? _____

What aggravates it? _____

Have you tried anything for your condition? yes no . If yes, what? _____

Have you had this condition before? yes no

Other Complaints: _____

Are you presently under a lot of stress? yes no. Low 1 2 3 4 5 6 7 8 9 10 High

Other Medical conditions (eg. Digestive conditions, gynecological conditions, etc.):

Check if you use: dietary supplements tobacco alcohol caffeine unprescribed drugs

What are your treatment goals?

Health History Form

I am aware that my treatments may involve one or more of the following: acupuncture, acupressure, cupping, gua sha, the manipulation of soft tissues and joints of the body, exercise, the use of electrical modalities in order to improve or maintain my physical functions and to reduce or eliminate pain.

I understand that my therapist is open to any questions throughout the treatment and that he/she believes in an open dialogue of discussion concerning the effects and procedures of therapy. I will inform him/her of any particular areas that I am uncomfortable having massaged, including specific issues related to being touched. I understand that I will be asked for specific consent for some specific techniques, if we have decided that those treatments will be beneficial to my well being, and if I am comfortable doing so.

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

Please note...

Payment is due at the time of treatment.

The therapy treatments are not covered by Alberta Health Care but may be covered by private insurance.

Missed appointments will be billed at the full rate, unless 24 hours notice is provided. Please be aware that insurance companies do not reimburse for missed appointments.

Signature _____

Date _____