Health History Outline – 16 years and older

Name _____ **Date of Birth (mm / dd / yyyy)**

Preferred Name (if different from above) _____ **Pronouns** _____

Full Address _____

Main Phone #_____**Email**_____ **Occupation** _____

Emergency Contact: Name/Phone # _____Relationship_____

Primary Care Physician Name _____Phone (if known)_____

Clinic Name _____ Last Physical Exam **(mm / dd / yyyy)**

Findings (if any) _____

Have you had x-rays in the last **2 years**? If yes, what part of your body? _____

Are you seeking treatment associated with an insurance claim? ☐ Yes ☐ No

Are you currently seeing any other complementary healthcare providers:

☐ Acupuncturist ☐ Chiropractor ☐ Massage Therapist ☐ Naturopath ☐ Osteopathic Manual Therapist

☐ Physiotherapist ☐ Other_____

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.

Please indicate areas of concern and treatment goals:

_____

_____

Have you sustained any significant physical injuries, surgeries, or other medical procedures? Include the nature and approximate dates.

_____

_____

_____

Please list any allergies or sensitivities:

_____

_____

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

_____

_____

When did the pain or problem start? _____

Does the feeling radiate and where? _____

Please check all that apply to pain.

☐	Achy	☐	Burning	☐	Gripping	☐	Numb	☐	Sharp	☐	Dull	☐	Sore	☐	Weak	☐	Stabbing
☐	Shooting	☐	Throbbing	☐	Tingling	☐	Loss of sensation	☐	Other:								

What is the frequency of the pain/altered sensation that you have described above?

☐ Constant ☐ Daily ☐ Weekly ☐ Interferes with sleep

What time of day is the sensation worse? ☐ AM ☐ PM

Grade the sensation _____/10

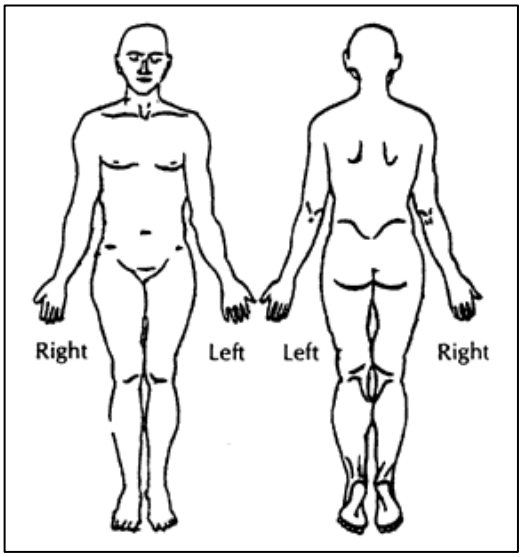
What relieves the condition? _____

What aggravates the condition? _____

Have you tried anything else to alleviate the condition? _____

_____

Please circle areas of concern.



Soft tissue and joint issues (please check all that apply)

☐	Cramps	☐	Spasms	☐	Sprains	☐	Strains	☐	Swelling	☐	Inflammation	☐	Bursitis
☐	Nerve pain	☐	Sciatica	☐	Tendonitis	☐	Scoliosis	☐	Arthritis	☐	Osteoarthritis	☐	Osteoporosis
☐	Rheumatism	☐	Paralysis	☐	Whiplash	☐	Other:						
☐	Any pins / plates / screws (where?)												

If you have checked any of the boxes above, please describe:

_____

_____

Respiratory Issues (please check all that apply)

☐	Asthma	☐	Bronchitis	☐	Chronic cough	☐	Chronic congestion	☐	Chronic sinusitis
☐	Emphysema	☐	Shortness of breath	☐	Other:				

Skin Issues (please check all that apply)

☐	Allergies	☐	Bruise easily	☐	Cold sores	☐	Dry skin	☐	Eczema	☐	Psoriasis	☐	Rash	☐	Sensitivities
☐	Warts	☐	Other:												

Gastrointestinal (please check all that apply)

☐	Acid reflux	☐	Colitis	☐	Constipation	☐	Crohn's	☐	Diarrhea	☐	Gallbladder	☐	GERD	☐	Hiatus hernia
☐	IBS	☐	Indigestion	☐	Nausea	☐	Ulcer	☐	Other:						

Cardiovascular (please check all that apply)

☐	Angina	☐	Arteriosclerosis	☐	Deep vein thrombosis	☐	Edema	☐	Heart attack
☐	Heart condition	☐	Heart failure	☐	Hemophilia	☐	High cholesterol	☐	High blood pressure
☐	Low blood pressure	☐	Phlebitis	☐	Varicose veins	☐	Other:		
☐	Pacemaker or similar device:								

☐ Heart attack (how long ago?) _____

Infectious diseases (please check all that apply)

☐ Hepatitis ☐ Herpes ☐ HIV/AIDS ☐ Skin conditions ☐ TB ☐ Other _____

Other (please check all that apply)

☐	Anxiety	☐	Blurred vision	☐	Cancer	☐	Depression	☐	Diabetes	☐	Dizziness
☐	Drug withdrawal	☐	Ear Problems	☐	Easily chilled	☐	Epilepsy	☐	Excessive appetite	☐	Excessive gas
☐	Excess Perspiration	☐	Fainting	☐	Fatigue	☐	Headaches	☐	Hearing loss	☐	Hemorrhage
☐	Hot flashes	☐	Hypoglycemia	☐	Immunosuppression	☐	Insomnia	☐	Kidney disease	☐	Liver disease
☐	Lump in throat	☐	Lupus	☐	Multiple sclerosis	☐	Nervousness	☐	Night sweats	☐	Organ disorder
☐	Palpitations	☐	Poor appetite	☐	Poor memory	☐	Recent injection	☐	Sexual dysfunction	☐	Vision loss

Do you wear: glasses / contact lenses / hearing aids / dentures / other _____

Do you have any other medical conditions or concerns not listed? ☐ Yes ☐ No

Please describe _____

Are you presently under a lot of stress? ☐ Yes ☐ No

Women (please check all that apply)

☐ Pregnant ☐ Recent birth ☐ PMS (headaches/bloating/cramps etc.) ☐ Oral contraceptives

Length of menstrual cycle _____ days Number of pregnancies _____

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, PSYCH-K®, 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 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.

We would like to kindly remind you that people may have allergies or sensitivities to fragrances. Please refrain from using scented products such as perfumes, colognes, and lotions when visiting the clinic. Thank you for your cooperation.

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