

Health History Outline

Name _____ Today's Date (mm / dd / yyyy)

Address _____

City _____ Prov. _____ Postal Code _____

Date of Birth _____ Occupation _____

Email _____ Phone(hm) _____ (cell) _____

Emergency Contact Name/Phone Number _____

Primary Care Physician Name _____ Phone _____

Clinic name / address _____

Last Physical Exam _____ Findings _____

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

Present involvement in other complementary healthcare

_____ Osteopathic Manual Therapist _____ Acupuncturist _____ Massage Therapist
_____ Physiotherapist _____ Chiropractor _____ Naturopath _____ Other (list) _____

Please indicate areas of concern and your treatment goals:

Have you ever sustained physical injuries (incl. motor vehicle accident, collision, job related, sports, other)?
If YES, please list with approximate dates _____

Past surgeries, include the nature and date _____

Please list any allergies or other sensitivities _____

Are you currently taking any medications? Please list _____

****Please note****

An accurate health history is important to ensure that it is safe for you to receive treatment, for your practitioner to provide treatment to you, as well to maintain the safety of other patients in the office.

If your health status changes in the future, please inform your practitioner.

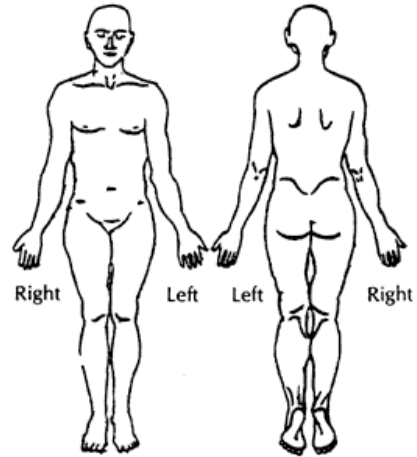
All information gathered for this treatment is confidential except as required by law or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

Pain/Altered Sensation (presently or in the past if applicable)

- Nature*
- | | |
|--|------------------------------------|
| <input type="checkbox"/> Achy | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Gripping |
| <input type="checkbox"/> Numb | <input type="checkbox"/> Sharp |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Sore |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Weak |
| <input type="checkbox"/> Loss of sensation | |
| <input type="checkbox"/> Other _____ | |

- Frequency*
- | | |
|--|----------------------------------|
| <input type="checkbox"/> Constant | <input type="checkbox"/> Daily |
| <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Acute | <input type="checkbox"/> Chronic |
| <input type="checkbox"/> Interferes with sleep | |

Please circle any areas of concern.



When did the pain/problem start? _____

Does the feeling radiate? Where? _____

Grade the sensation /10 _____ What time of day is the sensation worst? _____ AM _____ PM

What relieves your condition? _____

What aggravates your condition? _____

Have you tried anything else to relieve your condition? (list) _____

Have you had this condition before? Under what circumstances? _____

Soft Tissue/Joint Issues (and it's nature, if applicable)

- | | | |
|--|---|---|
| <input type="checkbox"/> Neck _____ | <input type="checkbox"/> Legs _____ | |
| <input type="checkbox"/> Shoulders _____ | <input type="checkbox"/> Knees _____ | |
| <input type="checkbox"/> Upper back _____ | <input type="checkbox"/> Feet _____ | |
| <input type="checkbox"/> Low back _____ | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Arms/hands _____ | | |
| <input type="checkbox"/> Swelling _____ | <input type="checkbox"/> Sciatica _____ | <input type="checkbox"/> Whiplash _____ |
| <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Sprains/ Strains _____ | <input type="checkbox"/> Scoliosis _____ |
| <input type="checkbox"/> Joint disease _____ | <input type="checkbox"/> Rheumatism _____ | <input type="checkbox"/> Arthritis/Osteoarthritis _____ |
| <input type="checkbox"/> Tendonitis/Bursitis _____ | <input type="checkbox"/> Spasms/ Cramps _____ | <input type="checkbox"/> Nerve pain/inflammation _____ |
| <input type="checkbox"/> Spinal disorder _____ | <input type="checkbox"/> Paralysis _____ | <input type="checkbox"/> Any pins/plates/ screws _____ |

Respiratory

- | | | |
|--|---|--|
| <input type="checkbox"/> Chronic cough _____ | <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Shortness of breath _____ | <input type="checkbox"/> Difficulties breathing _____ | <input type="checkbox"/> Chronic sinusitis _____ |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Chronic congestion _____ | <input type="checkbox"/> Other _____ |

Skin

- | | | |
|---|---|--|
| <input type="checkbox"/> Sensitivity _____ | <input type="checkbox"/> Rash _____ | <input type="checkbox"/> Warts _____ |
| <input type="checkbox"/> Athlete's foot _____ | <input type="checkbox"/> Cold sores _____ | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Shingles _____ | <input type="checkbox"/> Bruise easily _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dry skin _____ | <input type="checkbox"/> Eczema/psoriasis _____ | |

Gastrointestinal

- | | | |
|---|--|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Colitis/Crohn's | <input type="checkbox"/> Acid reflux/indigestion |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Abdominal aneurysm |
| <input type="checkbox"/> Bleeding ulcer | <input type="checkbox"/> Hiatus hernia | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Nausea | |

Cardiovascular

- | | | |
|---|---|---|
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Low Blood pressure | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Other _____ |

- Pace maker or other similar device
- Heart disease *type?* _____
- Heart attack *how long ago?* _____
- Chronic Congestive Heart Failure (CCF)

Women

- | | |
|--|--|
| <input type="checkbox"/> Pregnant (<i>due date</i> _____) | <input type="checkbox"/> Recent birth |
| Number of Pregnancies _____ | <input type="checkbox"/> Currently on oral contraception |
| <input type="checkbox"/> PMS (headaches, bloating, cramps, etc.) | |
| Length of menstrual cycle _____ | |

Other

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Hemorrhage |
| <input type="checkbox"/> Vision loss | <input type="checkbox"/> Hyperglycemia | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> Ear problems | <input type="checkbox"/> Cancer <i>type</i> _____ | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Recent injection | <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Organ disorder |

Do you wear glasses/ contact lenses/ hearing aid/ dentures/ other

- | | | |
|--|---|--|
| <input type="checkbox"/> Easily chilled | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Excessive appetite |
| <input type="checkbox"/> Excess perspiration | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Excessive gassiness |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Drug withdrawal | <input type="checkbox"/> Lump in the throat | <input type="checkbox"/> Syncope (fainting) |

Infectious diseases

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Skin conditions | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> TB | <input type="checkbox"/> Other _____ |

Do you regularly consume drugs or alcohol not listed as medications? (Including OTC, dietary supplements, tobacco, alcohol, caffeine, un-prescribed drugs) *Please list* _____

Do you have any other medical conditions or concerns not listed? _____

Are you presently under a lot of stress? _____

Waiver of Responsibility

I am aware that my treatments may include, but is not limited to, one or more of the following: Osteopathic Manual Therapy, Massage, CranioSacral Therapy, Acupuncture, Acupressure, Cupping, Gua Sha, BodyTalk Therapy, Reiki, the manipulation of soft tissue and joints of the body, exercise, the use of electrical modalities, in order to improve or maintain my physical functions and 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 additional 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 understand that this form will remain valid, and in effect for the duration of my care.

Please Note:

Payment is due at 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.

Date _____

Signature _____

We would like to kindly remind you to be aware that there are clients in our office who may have allergies or sensitivities to certain scents. Please be courteous when using scented products such as perfumes, colognes, and lotions. Thank you for your cooperation.

St. Albert Acupuncture & Wellness Inc.
Acupuncture, Athletic Therapy, NAET Allergy Elimination, Osteopathic Manual Therapy, Massage Therapy
CranioSacral Therapy, BodyTalk Therapy, Reiki