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_____

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****

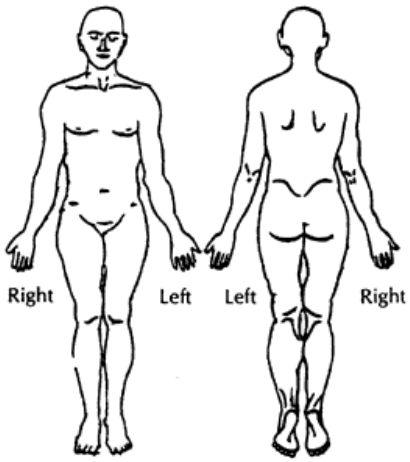
An accurate health history is important to ensure that it is safe for you to receive treatment, for your practitioner to provide treatment to you, as well to maintain the safety of other patients in the office.

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)

Please circle any areas of concern.



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

Frequency
_____ Constant _____Daily
_____ Weekly _____ Monthly
_____ Acute _____ Chronic
_____ Interferes with sleep

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)

_____ Neck _____ _____ Legs _____
_____ Shoulders _____ _____ Knees _____
_____ Upper back _____ _____ Feet _____
_____ Low back _____ _____ Other _____
_____ Arms/hands _____

_____ Swelling _____ Sciatica _____ Whiplash
_____ Osteoporosis _____ Sprains/ Strains _____ Scoliosis
_____ Joint disease _____ Rheumatism _____ Arthritis/Osteoarthritis
_____ Tendonitis/Bursitis _____ Spasms/ Cramps _____Nerve pain/inflammation
_____ Spinal disorder _____ Paralysis _____ Any pins/plates/ screws

Respiratory

_____ Chronic cough _____ Emphysema _____ Asthma
_____ Shortness of breath _____ Difficulties breathing _____ Chronic sinusitis
_____ Bronchitis _____ Chronic congestion _____ Other _____

Skin

_____ Sensitivity _____ Rash _____ Warts
_____ Athlete's foot _____ Cold sores _____ Allergies
_____ Shingles _____ Bruise easily _____ Other _____
_____ Dry skin _____ Eczema/psoriasis

Gastrointestinal

_____ Constipation _____ Colitis/Crohn's ____Acid reflux/indigestion

_____ Diarrhea
_____ Bleeding ulcer
_____ Gallbladder
_____ Hiatus hernia
_____ Nausea
_____ Abdominal aneurysm
_____ Other_____

Cardiovascular

_____ Poor circulation
_____ Arteriosclerosis
_____ Low Blood pressure
_____ Stroke
_____ Heart condition
_____ High Blood pressure
_____ Deep vein thrombosis
_____ Hemophilia
_____ Phlebitis
_____ Edema
_____ Varicose veins
_____ Other _____
_____ Pace maker or other similar device
_____ Heart disease *type?* _____
_____ Heart attack *how long ago?* _____
_____ Chronic Congestive Heart Failure (CCF)

Women

_____ Pregnant (*due date* _____)
Number of Pregnancies _____
_____ PMS (headaches, bloating, cramps, etc.)
Length of menstrual cycle _____
_____ Recent birth
_____ Currently on oral contraception

Other

_____ Headaches
_____ Blurred vision
_____ Vision loss
_____ Ear problems
_____ Hearing loss
_____ Recent injection
_____ Diabetes
_____ Hypoglycemia
_____ Hyperglycemia
_____ Cancer *type*_____
_____ Epilepsy
_____ Immunosuppression
_____ Liver Disease
_____ Hemorrhage
_____ Kidney infection
_____ Multiple Sclerosis
_____ Lupus
_____ Organ disorder

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

_____ Easily chilled
_____ Excess perspiration
_____ Night sweats
_____ Hot flashes
_____ Sexual dysfunction
_____ Drug withdrawal
_____ Palpitations
_____ Nervousness
_____ Insomnia
_____ Depression
_____ Poor memory
_____ Lump in the throat
_____ Anxiety
_____ Excessive appetite
_____ Poor appetite
_____ Excessive gassiness
_____ Fatigue
_____ Dizziness
_____ Syncope (fainting)

Infectious diseases

_____ Hepatitis
_____ Skin conditions
_____ TB
_____ HIV/AIDS
_____ Herpes
_____ 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 understand that treatments are not a replacement for care provided by a medical doctor or mental health professional.

I am aware that my treatments may include, but are not limited to, one or more of the following: Osteopathic Manual Therapy, Massage, CranioSacral Therapy, Acupuncture, Acupressure, Cupping, Gua Sha, BodyTalk Therapy, Reiki, PSYCH-K®, 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.

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.
Therapy treatments are not covered by Alberta Health Care but may be covered by private insurance.
We do not direct bill.
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.