Osteopathy Client Health History

Name: _____ Phone: H. _____

Address: _____ Bus: _____

City: _____ Postal Code: _____ Cell: _____

D.O.B. (mm/dd/yy)_____/_____/_____. Email:_____

Occupation: _____ Height _____ Weight: _____

What is your chief complaint: _____

_____

Recreational Activities: _____How did you hear about the clinic? _____.

Medical Doctor: _____ Doctor's Phone: _____

Doctor's Address:_____

HEALTH HISTORY

Please check the conditions that you are currently experiencing, or have experienced in the past.

Current/Previous

Head/Neck:

- ☐ ☐ Headaches

Types:_____

- ☐ ☐ Vision problems
- ☐ ☐ Earaches
- ☐ ☐ Jaw pain
- ☐ ☐ TMJ
- ☐ ☐ Braces
- ☐ ☐ Mouth surgery (root canals, wisdom teeth, etc)

Current/Previous

Respiratory:

- ☐ ☐ Shortness of Breath
- ☐ ☐ Chronic Cough
- ☐ ☐ Smoker
- ☐ ☐ Breathing Problems
- ☐ ☐ Asthma

Type: _____

Cardiovascular:

- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Poor circulation
- ☐ ☐ Stroke
- ☐ ☐ Varicose Veins
- ☐ ☐ Pins/Artificial Joints
- ☐ ☐ Pacemaker, Plates etc.

Surgery:

Type:_____

Date:_____

Current Symptoms:_____

Injury:_____

Type:_____

Date:_____

Current Symptoms:_____

Current/Previous

Skin:

- ☐ ☐ Skin Conditions

Types: _____

- ☐ ☐ Bruise easily
- ☐ ☐ Irritations?

Current/Previous

Other Conditions:

- ☐ ☐ Stress
- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Difficult Digestion
- ☐ ☐ Constipation
- ☐ ☐ Diabetes: onset_____
- ☐ ☐ Epilepsy
- ☐ ☐ Anemia
- ☐ ☐ Sinusitis
- ☐ ☐ Allergies _____
- ☐ ☐ Insomnia
- ☐ ☐ Diarrhea
- ☐ ☐ Crohns and Colitis
- ☐ ☐ Cancer _____
- ☐ ☐ Arthritis _____

MD Diagnosed? Area affected _____

Infections:

- ☐ ☐ Herpes
- ☐ ☐ Hepatitis
- ☐ ☐ Plantar Warts
- ☐ ☐ HIV, AIDS

Other:_____

M.D. diagnosed? Area affected_____

Current/Previous

Women:

- ☐ ☐ Painful Menstruation
- ☐ ☐ Gynecological Surgery
- ☐ ☐ Pregnant: Due Date _____

Children:_____

- ☐ ☐ Menopausal problems

Current/Previous

Muscle/Joint Pain

- ☐ ☐ Neck
- ☐ ☐ Low Back
- ☐ ☐ Upper Back
- ☐ ☐ Shoulders
- ☐ ☐ Legs: Right/Left
- ☐ ☐ Knee: Right/Left
- ☐ ☐ Arms: Right/ Left
- ☐ ☐ Ankles: Right/Left

Other:

_____Current

Medications

Name_____ For: _____

Name_____ For?_____

Name_____ For: _____

Name_____ For :_____

Other Healthcare:

- ☐ ☐ Chiropractic
- ☐ ☐ Physiotherapy
- ☐ ☐ Psychotherapy
- ☐ ☐ Massage Therapy
- ☐ ☐ Regular Exercise

Stool
Colour:_____
Consistency:_____
Frequency:_____
Bleeding:_____

Fractures
Where:_____
Casting:_____
Surgery:_____

Previous Treatments
Where:_____
With whom:_____
Outcome:_____

Motor Vehicle Accident:

Type of Injury: _____. Date: (mm/dd/yy) _____

Consent To Treatment: _____ **Date**: _____

Consent to contact as/when required. _____ Date: _____

A 24 hour cancellation notice is required or a service charge may apply.