

HEALTH HISTORY FORM

For your information:

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 us know. All information gathered for treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Date: _____ File #: _____

Occupation: _____ What is your primary complaint? _____

Family Physician: _____ Address? _____

Health History: Please indicate conditions you are experiencing, or have experienced:

<p>Respiratory</p> <ul style="list-style-type: none"><input type="checkbox"/> chronic cough<input type="checkbox"/> shortness of breath<input type="checkbox"/> bronchitis<input type="checkbox"/> asthma<input type="checkbox"/> emphysema <p>Cardiovascular</p> <ul style="list-style-type: none"><input type="checkbox"/> high blood pressure or hypertension<input type="checkbox"/> low blood pressure<input type="checkbox"/> CCHF<input type="checkbox"/> heart attack<input type="checkbox"/> phlebitis<input type="checkbox"/> stroke/CVA pacemaker or similar device<input type="checkbox"/> heart disease<input type="checkbox"/> vascular disease <p>Skin</p> <ul style="list-style-type: none"><input type="checkbox"/> skin conditions _____ <p>Other Conditions</p> <ul style="list-style-type: none"><input type="checkbox"/> osteoporosis<input type="checkbox"/> prolonged steroid use<input type="checkbox"/> inflammatory disease<input type="checkbox"/> collagen disease	<p>Other Conditions</p> <ul style="list-style-type: none"><input type="checkbox"/> loss of sensation<input type="checkbox"/> diabetes (onset: _____)<input type="checkbox"/> allergies (ie. anaphylaxis or skin irritation)<input type="checkbox"/> convulsions, seizures, or epilepsy<input type="checkbox"/> cancer or tumours<input type="checkbox"/> arthritis<input type="checkbox"/> sleeping disorder <p>Head/Neck</p> <ul style="list-style-type: none"><input type="checkbox"/> vision problems<input type="checkbox"/> vision loss<input type="checkbox"/> ear problems<input type="checkbox"/> hearing loss<input type="checkbox"/> headaches<input type="checkbox"/> head injury<input type="checkbox"/> concussion<input type="checkbox"/> oral or dental problems or injuries <p>Infections</p> <ul style="list-style-type: none"><input type="checkbox"/> hepatitis<input type="checkbox"/> skin conditions<input type="checkbox"/> TB<input type="checkbox"/> HIV / AIDS	<p>Women</p> <ul style="list-style-type: none"><input type="checkbox"/> pregnant (due: _____)<input type="checkbox"/> gynecological problems <p>Soft Tissue/joint discomfort and its nature</p> <ul style="list-style-type: none"><input type="checkbox"/> neck _____<input type="checkbox"/> low back _____<input type="checkbox"/> mid back _____<input type="checkbox"/> upper back _____<input type="checkbox"/> shoulders _____<input type="checkbox"/> arms _____<input type="checkbox"/> legs _____<input type="checkbox"/> knees _____<input type="checkbox"/> bones _____<input type="checkbox"/> other _____ <p>What is your general health status? _____</p>
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<p>Current Medications: _____</p> <p>Condition it treats: _____</p> <p>Surgery: _____ date: _____</p> <p>nature: _____</p> <p>Current injury: _____ date: _____</p> <p>nature: _____</p>	<ul style="list-style-type: none"><input type="checkbox"/> anticoagulants<input type="checkbox"/> corticosteroids<input type="checkbox"/> methotrexate<input type="checkbox"/> cyclosporine A <p>Present involvement in other Health Care:</p> <p style="text-align: center;">Yes No</p> <p>If yes, please specify: _____</p> <p>_____</p> <p>_____</p>
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Other Medical Conditions (e.g. digestive conditions, gynaecological conditions, hemophilia, etc.): _____

Of Special Note: (presence of internal pins, wires, artificial joints, special equipment): _____

Signature: _____ **Date:** _____