20 Prince Albert South, Kingsville 519 733-1000 12033 Tecumseh Rd E, Unit 3 226 280-2270

Health History Form

Please fill out this form as completely and accurately as possible. A complete and accurate health history is important to ensure the appropriate care and treatment plan can be given. All information gathered will remain private and confidential except for that which is required by law. If information is to be shared with other health care providers, your written permission will be required.

Name: _____ Date: _____
Address: _____Postal Code:_____
Phone: (H)_____ Email: _____
(B)_____ Family Physician :_____
(C)_____ Physician's Phone :_____
Date of Birth: _____ Occupation: _____
Other Health Care Providers:_____
Surgery/Injury:_____date:_____
Current Medication:_____
Condition it treats:_____
Extended Health Care Provider and policy #: _____
Do you have a work related injury?: _____ WSIB Claim #:_____
Are your injuries a result of a motor vehicle accident?:_____
How did you hear about the clinic?_____

Please indicate if you have or are experiencing any of the following conditions.

Respiratory
Circulation
_chronic cough
_shortness of breath
_bronchitis
_asthma
_emphysema
_sinus problems
_allergies
_varicose veins
_lymphedema
_poor circulation
_phlebitis/DVT
_other _____

Nervous System
_MS
_epilepsy
_numbness/tingling
_paralysis
_spinal cord injury
_head injury

Cardiovascular
_heart disease
_CCHF
_prev.heart attack
_pace maker
_stroke/CVA
_high blood pressure
_low blood pressure
_blood clots

Soft Tissue/Skeletal

_spasms/cramps
_fibromyalgia
_tension headaches
_strains/sprains
_tendonitis
_arthritis
_osteoporosis
_scoliosis
_fracture
_bone/joint disease
_jaw/TMJ pain
_herniated disc ___

Skin
_rash
_athlete's foot
_warts
_moles
_herpes/shingles

Infections
_HIV
_hepatitis Type___
_Tuberculosis
_skin infection

Digestive/Urogential
_diarrhea/constipation
_hernia Type_____
_ulcers
_organ dysfunction

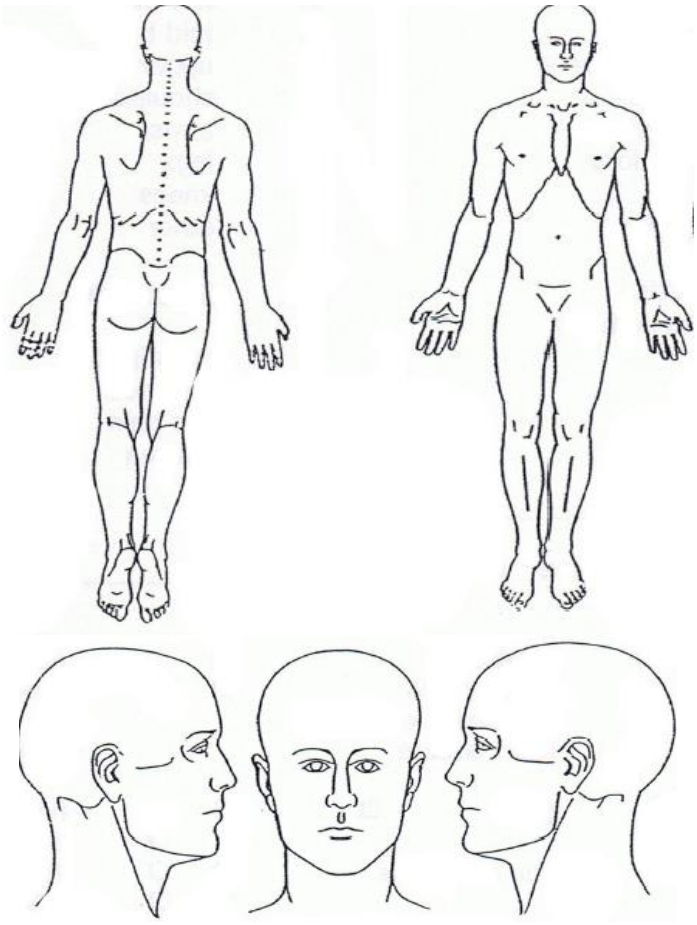
Gynecological
_pregnant due:_____
_hysterectomy
_menopause problem
_menstrual problem
_other (specify)
_____

Other
_vision loss/glasses
_hearing loss/hearing aid
_diabetes Type___
_thyroid
_cancer Type_____
_migraine headache
_ Pins/wires/artificial joints:_____

Please list any additional information:
_____
_____
_____
_____
_____
_____
_____
_____

HEALTH HISTORY FORM CONT'

What is your primary concern?_____
Please mark problem/painful areas:
"p"- pain "a"-aching "r"-radiating "n" numb/tingling "s" muscle/joint stiffness



Do you have limitation of movement and/or inflammation? Please explain:

_____
_____
_____

I acknowledge the facts given on this health history form are accurate and complete. If there are any changes in the future I accept full responsibility to inform the Osteopathic Practitioner. I understand that the information provided is kept private and confidential but may need to be shared with other Health Care Providers. I understand that by signing this disclosure statement I agree to the release of my information and clinical chart as needed or required by law. I am aware there is a fee for cancelled or missed appointments without 24hrs notice.

Client Signature_____Date:_____