HEALTH HISTORY FORM

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Personal Information

First Name: _____ Last Name: _____

Birth Date: _____ (dd/mm/yyyy) Sex: ☐ Male ☐Female
Address: _____ City:_____ Postal Code: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Family Doctor's Name:_____ Family Doctor's Contact Number:_____

Family Doctor's Address:_____

E-Mail Address:_____

☐ Interested in receiving e-newsletters from us Who may we thank for referring you?_____

Emergency Contact (name and phone number):_____

_____

Current Health Concern(s)

□ If there are no current concerns and this assessment is to ensure optimum health, function and wellness kindly check this box

Health Concern(s):

_____
_____
_____

If pain is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme):

Describe its character: Sharp, dull, ache, burning, tingling, throbbing, spasm
When did you first notice it? _____
What happened? _____

How often does it occur? _____

What relieves it? _____
What aggravates it? _____

Does it radiate or cause problems somewhere else? _____

Are there any associated or related concerns? _____

Have you seen any other health professionals for this? □Yes □No
If yes, whom? _____
What kind of treatment did you receive?_____
And what were the results?:_____

Other Health Concerns

Please note all other health concerns present or in the past. Please check the applicable boxes below:

□ Allergies
If yes, kindly list them:_____

□ Cancer
If yes, kindly list the type of cancer:_____
Are you in remission? □Yes □No
If yes, kindly name the number of months and/years?_____
What time of treatment did you receive? _____

□Lowered resistance □Indigestion □Loss of balance □Dizziness □Lightheadedness
□Difficulty concentrating □Fatigue □Heartburn □Bloating □Appendicitis
□Asthma □Emphysema □Pneumonia □ Frequent colds □Cataracts
□Vision changes □Bleeding disorders □Diabetes □Hypoglycemia □Epilepsy
□Heart Disease □Hypertension □Headaches □Migraines □Hepatitis
□High cholesterol □Difficulty digestion □Constipation □Loose stools □Hernia
□Herniated Disc □Kidney Disease □Liver disease □Multiple Sclerosis □Osteoarthritis
□Osteoporosis □Pinched nerve □Rheumatoid arthritis □Numbness and tingling
□Pins and needles □Prostate problems □Parkinson's Disease □Stroke
□Thyroid problem □Tonsillitis □Ulcers □Ulcerative colitis

Other:_____

For women: Are you pregnant? □Yes □No
If yes, how far along are you? _____ Estimated Due Date:_____

Chemical and Physical Stresses

Did you sustain any significant injuries, falls or traumas during infancy or childhood? □Yes □No
If yes please explain:_____

Have you had any significant injuries, falls or traumas during adulthood? □Yes □No
If yes please explain:_____

Any hospital visits? □Yes □No
If yes, please kindly list the date and the reason for the visit?_____

Have you had any surgeries, fractures, car accidents? □Yes □No
If yes please explain and list dates:_____

Are you in prolonged postures? (ie: repetitive work, lifting, sitting, driving) □Yes □No
If yes, please explain:_____

What is your exercise level ? □Low □Moderate □Daily □Heavy
What is your usual exercise routine?_____

What position do you sleep in? □Back □Side □Stomach
For how many hours?_____

Have you had any fractured bones or dislocations? □Yes □No
If yes, please list the location and year of injury/injuries:_____

Have you ever been involved in a motor vehicle accident or accidents? □Yes □No
If yes, what happened and when did the incident occur? _____

Are you taking prescription or over-the-counter medications? □Yes □No
If yes, please explain what you are taking and why?:_____

Are you currently taking supplements? □Yes □No
If yes please explain what you are taking and why?:_____

Do you smoke? □Yes □No □Quit
If yes, how many times a day to you smoke and how many cigarettes do you smoke?:_____

Family Health History

Please note any health issues that are present with family members such as parents, siblings, significant other or children. Please check the appropriate boxes below:

□Cancer □Hypertension □Stroke □Arthritis □Kidney disease
□Dementia □Diabetes
□Other:_____