



OSTEOPATHY HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive treatments. If your health status changes, please let us know. All information collected is confidential, except as required or allowed by law or to facilitate diagnosis or treatment.

PERSONAL HISTORY				
				DATE: DD / MM / YYYY
FIRST NAME	LAST NAME			
ADDRESS	CITY	POSTAL CODE	DATE OF BIRTH DD / MM / YYYY	
()	()	EMAIL ADDRESS (For Appointment Reminders)		
HOME PHONE	MOBILE PHONE			
EMPLOYER INFORMATION				
EMPLOYER		OCCUPATION		
ADDRESS	CITY	POSTAL CODE	() WORK PHONE	
HOW DID YOU HEAR ABOUT OUR OFFICE?				
<input type="checkbox"/> Internet	<input type="checkbox"/> Phone Book	<input type="checkbox"/> Massage Therapist	<input type="checkbox"/> Friend / Family _____	
<input type="checkbox"/> Brochure	<input type="checkbox"/> Medical Doctor	<input type="checkbox"/> Personal Trainer	<input type="checkbox"/> Other _____	
PREVIOUS OSTEOPATHY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	OTHER PRACTITIONERS SEEN	
OSTEOPATHIC MANUAL PRACTITIONERS NAME _____ CLINIC NAME _____	DD / MM / YYYY DATE OF LAST VISIT (APPROX.)		MESSAGE THERAPY <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____ CHIROPRACTOR <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____ PHYSIOTHERAPY <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____ ACUPUNCTURE <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____ OTHER _____ <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____	
PRIMARY CARE MEDICAL DOCTOR	DO YOU WEAR FOOT ORTHOTICS <input type="checkbox"/> YES <input type="checkbox"/> NO			
I authorize Target Therapeutics to send a report. <input type="checkbox"/> NO <input type="checkbox"/> YES INITIAL _____ DOCTORS NAME _____ CITY _____	HOW LONG HAVE YOU WORN THEM? _____ HOW LONG SINCE YOUR LAST PAIR? _____			

OSTEOPATHY HEALTH HISTORY FORM

PAST MEDICAL HISTORY

GENERAL

- Epilepsy
- Chronic Infections
- Diabetes
- Cancer
- Anemia
- Hyperthyroid
- Hypothyroid
- Hypoglycaemia

CARDIOVASCULAR

- Congestive Heart Failure
- Stroke
- Heart Attack
- High Blood Pressure
- Low Blood Pressure
- Deep Vein Thrombosis
- Heart Disease
- Pacemaker

RESPIRATORY

- Shortness of Breath
- Bronchitis
- Pneumonia
- Emphysema
- Asthma
- Sinus Problem
- COPD

HEAD/NECK

- Vision Loss
- Hearing Loss
- Tinnitus
- Dizziness
- Loss of Balance
- Excessive Gas

NERVOUS

- Loss of Sensation
- Chronic Pain
- Numbness/Tingling

REPRODUCTIVE

- Pregnancies
- Hysterectomy
- Vasectomy

INFECTIONS

- Hepatitis
- HIV
- Tuberculosis

SKIN CONDITIONS

- Bruise Easily
- Eczema
- Psoriasis

How often do you get sick? _____

Do you have any allergies to any drugs, herbs, foods, animals, or other?

Please List: _____

Do you currently use any of the following (indicate how often, how much and for how long)

Alcohol	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____	Typical Pain Relief	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Marijuana	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____	Coffee	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Tobacco	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____	Tea	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

Medications: _____

Have you ever been diagnosed with cancer? YES NO if yes, please describe: _____

CURRENT LIFESTYLE

Your general state of health is: Excellent Good Average Fair Poor

What are your main interests and hobbies? _____

How often do you exercise per week/month? _____

How much time do you spend exercising each time? _____

Type of exercise? _____

OSTEOPATHY HEALTH HISTORY FORM

CURRENT HEALTH CONDITION

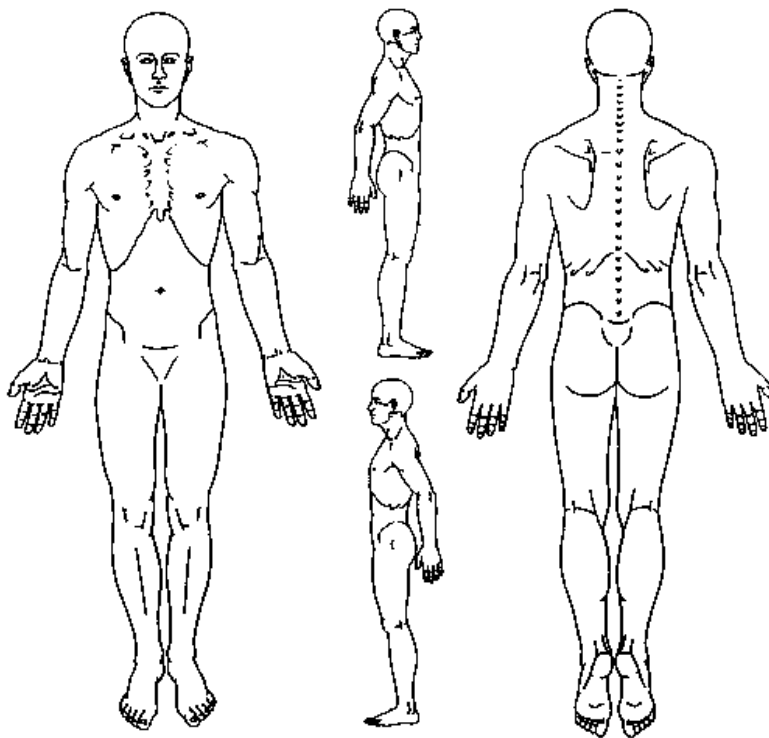
Primary Complaint (Reason for coming in): _____

Please check off all current health concerns, injuries and previous surgeries. Provide details if necessary:

- | | | |
|---|---|--|
| <input type="checkbox"/> Concussion _____
<input type="checkbox"/> Neck Injury _____
<input type="checkbox"/> Head Injury _____
<input type="checkbox"/> Vision _____
<input type="checkbox"/> Ear Infections _____
<input type="checkbox"/> Dental Work _____
<input type="checkbox"/> Lymphatic _____ | <input type="checkbox"/> Facial Surgery _____
<input type="checkbox"/> Upper Extremity _____
<input type="checkbox"/> Pelvic Injury _____
<input type="checkbox"/> Hip _____
<input type="checkbox"/> Mid-Spine Injury _____
<input type="checkbox"/> Lower Back Injury _____
<input type="checkbox"/> Knees _____
<input type="checkbox"/> Ankle _____
<input type="checkbox"/> Foot _____ | <input type="checkbox"/> Throat Infections _____
<input type="checkbox"/> Cardiac _____
<input type="checkbox"/> Respiratory _____
<input type="checkbox"/> Digestive _____
<input type="checkbox"/> Liver _____
<input type="checkbox"/> Spleen _____
<input type="checkbox"/> Renal _____
<input type="checkbox"/> Pancreas _____
<input type="checkbox"/> Immunity _____
<input type="checkbox"/> Reproductive _____ |
|---|---|--|

Please circle the severity of your pain at this time: NO PAIN 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 WORST PAIN EVER

On the diagrams below please indicate problem areas using circular shapes:



INFORMED CONSENT

By signing below, I consent to Manual Osteopathic Treatment with Kevin Lau D.O.M.P., D.Sc.O. and understand that all information, both written and verbal, will be kept strictly confidential, unless otherwise authorized by you, the patient.

If under the age of 16, your legal guardian must be present during each treatment and must sign below. All information will be relayed to you and your guardian.

 FULL NAME (PLEASE PRINT)

 DD / MM / YYYY
 DATE

SIGNATURE