Personal Information:

Today's Date:_____
Day/month/year

Name: _____
First Last

Date of Birth: _____ _____ _____
Day Month Year

Height: _____ Weight: _____

Address : _____

_____

_____

Phone: Home _____
Other _____

Email: _____

Name and Number of Emergency Contact:

_____
Name

_____
Number

_____
Relationship

Family Doctor:

_____
Name

_____
Phone / Address

Other Health Care Practitioners:

_____
Name

_____
Phone / Address

Type of Work/Occupation

_____
Part Time / Full Time

How did you hear about our office?

_____

Detailed Health History:

What is your primary reason for seeking treatment?

_____

Are there any secondary complaints?

_____

_____

_____

Have you consulted anyone else for this condition? _____

Do any of these interfere with...
work? _____
Sleep? _____
Hobbies? _____
home life?_____

When I feel stressed, I notice.....
headaches _____
mood swings _____
stomach issues _____
skin issues _____ where _____
muscle / joint pain _____ where _____
other_____

Surgeries, Injuries & Car Accidents:

_____
Date & Nature

_____
Date & Nature

_____
Date & Nature

_____
Date & Nature

_____
Date & Nature

Medical Conditions:

_____

_____

_____

Other: (pins, wires, plates, pace maker, etc.)

_____

_____

Current Medications:

_____
Type / Condition / Dosage

_____
Type / Condition / Dosage

_____
Type / Condition / Dosage

Supplements, Vitamins & Herbal:

_____
Type / Reason for Use

_____
Type / Reason for Use

_____
Type / Reason for Use

What is your daily water intake? _____

For Women:

Have you given birth? Yes / No
If so, did you receive an epidural? Yes / No
Have you had a C-section? Yes / No
Do you experience period pain? Yes / No
If so, can you describe where
_____

are your cycles regular? Yes / No
are they ? heavy / normal / light

Please indicate any conditions that you are or have experienced:

Respiratory:
- O chronic cough
- O Shortness of breath
- O Bronchitis
- O Asthma

Cardiovascular:
- O High Blood Pressure
- O Low Blood Pressure
- O Poor Circulation
- O Chronic congestive heart failure
- O Heart Attack
- O Heart Disease
- O Stroke
- O Pace maker
- O Varicose veins

Digestive and Urinary:
- O Liver conditions _____
- O difficult digestion
- O Gall Bladder Conditions _____
- O Constipation
- O Kidney Conditions _____
- O Poor Appetite
- O Bladder Conditions _____
- O IBS
- O Crohn's/Colitis

Other:
- O Diabetes type_____
- O Arthritis type_____
- O Cancer type_____
- O Allergies
- O Osteoporosis
- O Insomnia
- O Epilepsy
- O HIV/Aids
- O Hepatitis
- O TB
- O Other (list all)

_____
_____

Additional Information:

Privacy

An Accurate health history is important to ensure that it is safe for you receive treatment, and if modifications are indicated. Please inform me as soon as possible of any changes to your status in the future.

All information gathered is completely confidential except where required or allowed by law, or to facilitate assessment/treatment. You will be asked to provide written authorization for the release of any information.

Manual Osteopathy:

Regular Treatment $50

Cancellation Policy:

All appointments are reserved for you alone. A missed appointment is a loss for you, your therapist and for another patient who may have needed treatment.

If you are unable to keep a scheduled appointment, please give at least 24 hours notice for rescheduling. A missed appointment without this notice will be billed the full treatment fee.

I _____ assure that I have completed this form to the best of my knowledge and that no false or misleading statements have been made as they could lead to ineffective treatment and/or injury. I have read and understand all claims made within.

Signature: _____