430 Browns Line, Etobicoke, ON, M8W 3T9 (416) 253-5433

For your information:

Health History Form

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes 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: ______________________ D.O.B.: ______________ File #: __________

Occupation: __________________ What is your primary complaint? ____________________

Family Physician: ______________________ Phone#________________

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

Respiratory
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema
- ☐ other: __________

Cardiovascular
- ☐ high blood pressure or hypertension
- ☐ low blood pressure
- ☐ CCHF
- ☐ heart attack
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart disease

Is there a family history of any of the above
☐ Yes ☐ No

Other Conditions
- ☐ osteoporosis
- ☐ prolonged steroid use
- ☐ inflammatory disease
- ☐ collagen disease
- ☐ skin conditions, what?

____

Other Conditions
- ☐ loss of sensation, where?__________
- ☐ diabetes (onset: ________)
- ☐ allergies / hypersensitivity
  to what?______________
  What kind of reaction?__________
- ☐ epilepsy
- ☐ cancer, where?__________
- ☐ sleeping disorder
- ☐ arthritis

Is there a family history of arthritis?
☐ Yes ☐ No

Head/Neck
- ☐ vision problems / glasses
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss
- ☐ history of headaches
- ☐ concussion
- ☐ oral or dental problems or injuries

Infections
- ☐ hepatitis ☐ HIV / AIDS
- ☐ TB ☐ Herpes

Women
- ☐ pregnant (due:______________)
- ☐ gynecological problems, what?
  ____

Soft Tissue/Joint Discomfort and its nature:
- ☐ neck ______________
- ☐ low back ______________
- ☐ mid back ______________
- ☐ upper back______________
- ☐ shoulders ______________
- ☐ arms ______________
- ☐ phlebitis / varicose veins ________
- ☐ legs ______________
- ☐ knees ______________
- ☐ bones ______________
- ☐ other ______________

Overall, how is your general health?

____
____
____

Current Medications: ______________________

☐ anticoagulants ☐ corticosteroids
☐ methotrexate ☐ cyclosporine A

Condition it treats: ______________________

Surgery(s): ________________ date(s):________
nature:______________________

Current injury: ________________ date: ______
nature:______________________

Are you currently receiving treatment elsewhere?
☐ Yes ☐ No

If yes, for what? : ______________________
____

Other Medical Conditions (e.g. digestive conditions, hemophilia, mental illness, etc.):______________________

____

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

What is the reason you are seeking therapy? ______________________

Signature:________________ Date:______________