

**HEALTH HISTORY FORM**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

HOME TEL: \_\_\_\_\_ WORK # \_\_\_\_\_ CELL# \_\_\_\_\_

E-MAIL: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

DOCTOR'S NAME: \_\_\_\_\_ DOCTOR'S PHONE NUMBER: \_\_\_\_\_

WHERE DID YOU HEAR ABOUT THE CLINIC? \_\_\_\_\_

CHIEF COMPLAINT TODAY? \_\_\_\_\_

THE INFORMATION ON THIS FORM IS CONFIDENTIAL AND WILL BE USED FOR NO OTHER PURPOSE THAN FOR THE THERAPIST'S CLINICAL RECORDS. **WE REGRET WE MUST CHARGE FOR APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS NOTICE.**

I the undersigned believe the information given on this medical history is correct to the best of my knowledge.

SIGNATURE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

Please check the following conditions that you experience frequently and currently. This information must be accurate

**Cardiovascular/Respiratory:**

- Stroke
- Heart disease
- Low blood pressure
- High blood pressure
- Chronic Congestive heart failure
- Poor Circulation
- Varicose Veins
- Chronic Bronchitis
- Emphysema
- Myocardial Infarction
- Other: \_\_\_\_\_

**Skin:**

- Psoriasis
- Athlete's foot
- Warts
- Eczema
- Other: \_\_\_\_\_

**Digestive/Uro-genital:**

- Irritable Bowel Syndrome
- Constipation
- Difficult Digestion
- Liver/Gall Bladder
- Kidney/Bladder
- Diabetes Type: \_\_\_\_\_
- Other: \_\_\_\_\_

**Nervous System:**

- Multiple Sclerosis
- Cerebral Palsy
- Parkinson's Disease
- Bell's Palsy
- Epilepsy
- Spinal Cord Injury
- Other: \_\_\_\_\_

**Reproductive:**

- Endometriosis
- Hysterectomy
- Menopause
- Pelvic Inflammatory Disease
- Pregnancy: \_\_\_\_\_
- Due Date: \_\_\_\_\_
- # of children \_\_\_\_\_
- Menstrual Problems
- Other: \_\_\_\_\_

**Other conditions:**

- Sports injuries
- Dislocations
- Fractures
- Whiplash
- Tendonitis/Bursitis
- Plantar Fasciitis
- Scoliosis
- Ankylosing Spondylitis
- Arthritis Type: \_\_\_\_\_
- TMJ Dysfunction
- Degenerative Disc Disease
- Depression
- Fibromyalgia
- Insomnia
- Cancer Type: \_\_\_\_\_
- Other: \_\_\_\_\_

**Infectious Conditions:**

- Hepatitis Type: \_\_\_\_\_
- HIV
- Tuberculosis
- Other: \_\_\_\_\_

**Muscle/Joints:**

Region	Current pain/stiffness	Previous pain/ stiffness
Neck	_____	_____
Upper Back	_____	_____
Mid Back	_____	_____
Low Back	_____	_____
Shoulders	_____	_____
Arm: left/right	_____	_____
Elbow: left/right	_____	_____
Hand: left/right	_____	_____
Leg: left/right	_____	_____
Knee: left/right	_____	_____
Foot: left/right	_____	_____
Other:	_____	_____

**Other Health Care Professionals**

Chiropractic \_\_\_\_\_  
Physiotherapist \_\_\_\_\_  
Medic Alert Bracelet Y N

**Allergies**

	Yes	No
Nuts	_____	_____
Food	_____	_____
Drug	_____	_____
Other	_____	_____

**Other Medical Conditions**

\_\_\_\_\_  
\_\_\_\_\_

**Medications Currently Taking:**

Names: \_\_\_\_\_

\_\_\_\_\_

Reasons: \_\_\_\_\_

\_\_\_\_\_

**HEALTH HISTORY INFORMATION**

**Surgery:** \_\_\_\_\_ **Injury:** including Motor Vehicle Accidents \_\_\_\_\_ **Medication:** \_\_\_\_\_  
Type: \_\_\_\_\_ Type: \_\_\_\_\_ Name: \_\_\_\_\_  
Date: \_\_\_\_\_ Date: \_\_\_\_\_ for What Condition? \_\_\_\_\_  
Current Symptoms: \_\_\_\_\_ Current Symptoms: \_\_\_\_\_  
\_\_\_\_\_

Special Note: (Pins, wires, artificial joints or limbs, special equipment such as wheelchairs etc.) \_\_\_\_\_

**FAMILY HEALTH INFORMATION**

Some health problems are hereditary. Information about your family may be helpful in assessing your current condition.

Relationship: \_\_\_\_\_ Illness: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Illness: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Illness: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Illness: \_\_\_\_\_

**CASE HISTORY INFORMATION UPDATES:**

Date (DD/MM/YY)	Signature
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**FOR THERAPISTS USE ONLY**

**PAIN ASSESSMENT**

When did it start? \_\_\_\_\_ What makes it better? \_\_\_\_\_  
Where is it located? \_\_\_\_\_ What makes it worse? \_\_\_\_\_  
Does it travel from the location? \_\_\_\_\_ What does it feel like? \_\_\_\_\_  
Where? \_\_\_\_\_ How bad is it?    1    2    3    4    5    6    7    8    9    10 \_\_\_\_\_  
How does it affect your activities of daily living? \_\_\_\_\_

**Other Notes:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_