Patient Health History Form

Name: _____ Date: ___/___/___ (Day Mth Yr)

Address: _____City: _____ Postal Code: _____

Home Phone: _____ Work Phone:_____ Ext: _____

Cell Phone: _____ Email Address: _____

Date of Birth: ____/ ____ / ____ (Day Mth Yr) Occupation:_____

How did you hear about our clinic?_____

Cardiovascular

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis/varicose veins
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart disease

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

Respiratory

- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

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

Infections

- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Other Conditions

- ☐ loss of sensation, where? _____
- ☐ diabetes, onset: _____
- ☐ allergies/hypersensitivity to What? _____ Type of reaction: _____
- ☐ epilepsy
- ☐ cancer, where? _____
- ☐ arthritis

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

Head/Neck

- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Women

- ☐ pregnant, due date: _____
- ☐ gynecological conditions, what? _____

Primary Care Physician:_____

Address:_____

_____

Current Medications:_____

_____

Condition it treats:_____

_____

Surgery – Date _____

Nature: _____

Injury – Date _____

Nature: _____

Additional Medical Information (e.g: digestive conditions, haemophilia, oseoporosis, mental illness)

_____

_____

Do you have any internal pins, wires, or artificial joints?

☐ Yes ☐ No

Details:_____

_____

What is the reason you are seeking Massage/Osteopathy?

_____

_____

Notes:

Date of Initial Health History:
Update 1:_____
Update 2:_____
Update 3:_____
Update 4:_____

Thank you for choosing Rosedale Wellness Centre