Health History Form

Please complete this Health History form as accurately as possible. This will ensure that you receive safe and effective treatment. If at any time your health status changes, please let me know as soon as possible prior to your treatment. All information is strictly confidential and cannot be released to anyone without your written consent.

Name: ___________________________________ Age: _____ D.O.B: (MM/DD/YYYY) _____________

Address: ____

City: ___________________________ Postal Code: _____________ Phone #: __________________

Email: ____

Height: __________________________________ Weight: __________________________________

Occupation: ____

Family Physician: ____

Phone: ________________________ Address: ____

Emergency Contact: ____

Phone: ________________________ Address: ____

Reason For Treatment: ____

Health Care Benefits: Yes ☐ No ☐

Head & Neck:
- ☐ Headaches
  Type: ______________
- ☐ Dizziness
- ☐ Earaches
- ☐ Sinus Issues
- ☐ Neck Pain

Muscle & Joint
- ☐ Pain
- ☐ Stiffness
- ☐ Swelling
- ☐ Limited Motion
- ☐ Fatigue
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Back Pain (Upper/Mid/Lower)
- ☐ Shoulder Pain

Women/Menstruation
- ☐ Painful
- ☐ Heavy
- ☐ Light
- ☐ Normal
- ☐ Irregular
- ☐ Absent
- ☐ Pregnant
- ☐ Children # _______
- ☐ Menopause
- ☐ Hysterectomy

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other: ________________

Skin
- ☐ Sensitive Skin
- ☐ Rashes
- ☐ Acne
- ☐ Cold Sores
- ☐ Bruise Easily
- ☐ Varicose Veins
- ☐ Deep Vein Thrombosis
- ☐ Eczema/Psoriasis
- ☐ Recent: Tattoos/Piercings/Stitches

Cardiovascular
- ☐ High/Low Blood Pressure
- ☐ Poor Circulation
- ☐ Heart Disease
- ☐ Heart Surgery
- ☐ Pacemaker
- ☐ Stroke
- ☐ Phlebitis

Digestive
- □ Poor Digestion
- □ IBS
- □ Diarrhea
- □ Constipation
- □ Difficult Digestion
- □ Liver/Gallbladder
- □ Kidney/Bladder

Diet
- □ Regular Meals
- □ Irregular Eating Habits
- □ Caffeine
- □ Regular Alcohol Use
- □ Recreational Drug Use
- □ Smoke - Package/day: ____

Other
- □ Vision Problems
- □ Vision Loss
- □ Vertigo
- □ Hearing Loss
- □ Ear Problems
- □ Hepatitis – Type: ____
- □ HIV
- □ TB
- □ Cancer
- □ Sleep Disorder

General Stress Level
- □ High
- □ Moderate
- □ Low

Exercise
- □ Regular
- □ Occasional
- □ Little

Previous Health Care
- □ Massage
- □ Chiropractic
- □ Physiotherapy
- □ Other:

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Date of Last Physical

____

Allergies:

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____

Current medications and reason for use:

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____

Current herbal products/supplements and reason for use:

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____

Surgeries:

____

____

Car Accidents:

____

____

Injuries:

____

____

Other: (Pins, Wires, Prosthetics, Walker, Cane, etc.)

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Melissa Jeffreys M.OMSc • 905.746.9330 • melissa.osteopathy@gmail.com