OSTEOPATHY HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive treatments. If your health status changes, please let us know. All information collected is confidential, except as required or allowed by law or to facilitate diagnosis or treatment.

PERSONAL HISTORY

DATE: DD / MM / YYYY

FIRST NAME LAST NAME

ADDRESS | CITY | POSTAL CODE | DD / MM / YYYY DATE OF BIRTH

( ) HOME PHONE | ( ) MOBILE PHONE | EMAIL ADDRESS (For Appointment Reminders)

EMPLOYER INFORMATION

EMPLOYER | OCCUPATION

ADDRESS | CITY | POSTAL CODE | ( ) WORK PHONE

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Internet ☐ Phone Book ☐ Massage Therapist ☐ Friend / Family _____

☐ Brochure ☐ Medical Doctor ☐ Personal Trainer ☐ Other _____

PREVIOUS OSTEOPATHY ☐ YES ☐ NO

OSTEOPATHIC MANUAL PRACTICIONERS NAME | DD / MM / YYYY DATE OF LAST VISIT (APPROX.)

CLINIC NAME

OTHER PRACTITIONERS SEEN

MESSAGE THERAPY ☐ **Y** ☐ **N** **DATE** _____

CHIROPRACTOR ☐ **Y** ☐ **N** **DATE** _____

PHYSIOTHERAPY ☐ **Y** ☐ **N** **DATE** _____

ACUPUNCTURE ☐ **Y** ☐ **N** **DATE** _____

OTHER _____ ☐ **Y** ☐ **N** **DATE** _____

PRIMARY CARE MEDICAL DOCTOR

I authorize Quantum HealthCare to send a report.

☐ **NO** ☐ **YES** **INITIAL** _____

DOCTORS NAME | CITY

DO YOU WEAR FOOT ORTHOTICS ☐ YES ☐ NO

HOW LONG HAVE YOU WORN THEM? _____

HOW LONG SINCE YOUR LAST PAIR? _____

OSTEOPATHY HEALTH HISTORY FORM

PAST MEDICAL HISTORY

GENERAL

- ☐ Epilepsy
- ☐ Chronic Infections
- ☐ Diabetes
- ☐ Cancer
- ☐ Anemia
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Hypoglycaemia

CARDIOVASCULAR

- ☐ Congestive Heart Failure
- ☐ Stroke
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Deep Vein Thrombosis
- ☐ Heart Disease
- ☐ Pacemaker

RESPIRATORY

- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Asthma
- ☐ Sinus Problem
- ☐ COPD

HEAD/NECK

- ☐ Vision Loss
- ☐ Hearing Loss
- ☐ Tinnitus
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Excessive Gas

NERVOUS

- ☐ Loss of Sensation
- ☐ Chronic Pain
- ☐ Numbness/Tingling

REPRODUCTIVE

- ☐ Pregnancies
- ☐ Hysterectomy
- ☐ Vasectomy

INFECTIONS

- ☐ Hepatitis
- ☐ HIV
- ☐ Tuberculosis

SKIN CONDITIONS

- ☐ Bruise Easily
- ☐ Eczema
- ☐ Psoriasis

How often do you get sick? _____

Do you have any allergies to any drugs, herbs, foods, animals, or other?
Please List: _____

Do you currently use any of the following (indicate how often, how much and for how long)

Alcohol ☐ **YES** ☐ **NO** _____

Marijuana ☐ **YES** ☐ **NO** _____

Tobacco ☐ **YES** ☐ **NO** _____

Typical Pain Relief ☐ **YES** ☐ **NO** _____

Coffee ☐ **YES** ☐ **NO** _____

Tea ☐ **YES** ☐ **NO** _____

Medications: _____

Have you ever been diagnosed with cancer? ☐ **YES** ☐ **NO** if yes, please describe: _____

CURRENT LIFESTYLE

Your general state of health is: ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

What are your main interests and hobbies? _____

_____

How often do you exercise per week/month? _____

How much time do you spend exercising each time? _____

Type of exercise? _____

OSTEOPATHY HEALTH HISTORY FORM

CURRENT HEALTH CONDITION

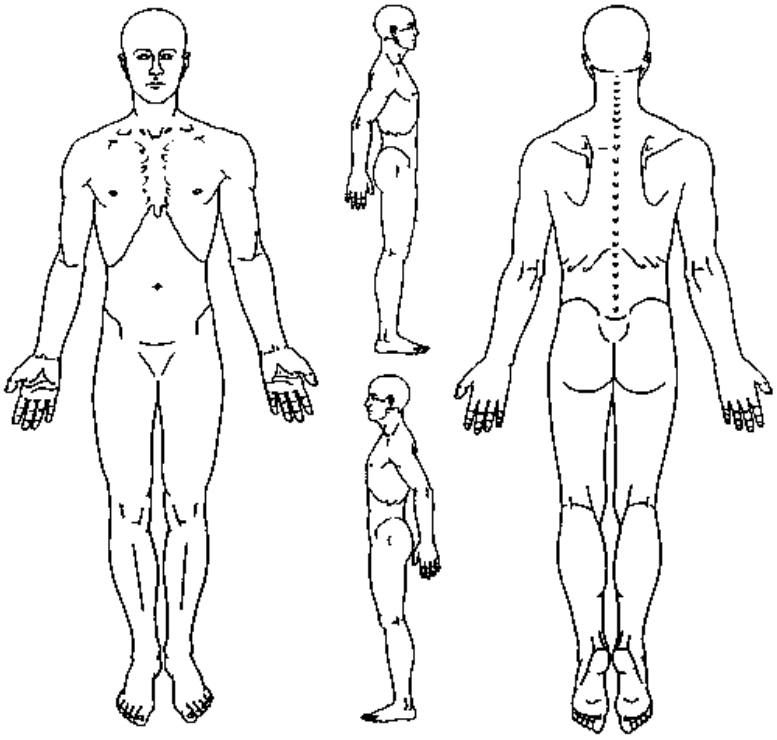
Primary Complaint (Reason for coming in): _____

Please check off all current health concerns, injuries and previous surgeries. Provide details if necessary:

- ☐ Concussion _____
- ☐ Neck Injury _____
- ☐ Head Injury _____
- ☐ Vision _____
- ☐ Ear Infections _____
- ☐ Dental Work _____
- ☐ Lymphatic _____
- ☐ Facial Surgery _____
- ☐ Upper Extremity _____
- ☐ Pelvic Injury _____
- ☐ Hip _____
- ☐ Mid-Spine Injury _____
- ☐ Lower Back Injury _____
- ☐ Knees _____
- ☐ Ankle _____
- ☐ Foot _____
- ☐ Throat Infections _____
- ☐ Cardiac _____
- ☐ Respiratory _____
- ☐ Digestive _____
- ☐ Liver _____
- ☐ Spleen _____
- ☐ Renal _____
- ☐ Pancreas _____
- ☐ Immunity _____
- ☐ Reproductive _____

Please circle the severity of your pain at this time: NO PAIN **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** WORST PAIN EVER

On the diagrams below please indicate problem areas using circular shapes:



INFORMED CONSENT

By signing below, I consent to Manual Osteopathic Treatment with James Frommer DO and understand that all information, both written and verbal, will be kept strictly confidential, unless otherwise authorized by you, the patient.

If under the age of 16, your legal guardian must be present during each treatment and must sign below. All information will be relayed to you and your guardian.

_____ DD / MM / YYYY

FULL NAME (PLEASE PRINT) DATE

_____

SIGNATURE