Osteopathy Health History Form

Please complete this health history form as accurately as possible to ensure that you receive a safe and effective treatment. If at any time your health status changes, please inform me as soon as possible prior to your treatment. All information is strictly confidential and will not be released to anyone without your written consent. Feel free to ask me questions you may have.

Name		
Address	City	Postal Code
Home Phone	Work Phone	Mobile Phone
Email Address		
Date of Birth	Height	Weight
Occupation		
Family Physician		Phone
Emergency Contact		Phone

Reasons for treatment:

HEALTH HISTORY
Please check all that apply:

General Health Status	**Digestive**	**Head & Neck**
◯ Good ◯ Average ◯ Poor	☐ Poor digestion	☐ Headaches
General Stress Levels	☐ IBS	☐ Type:
◯ High ◯ Average ◯ Low	☐ Diarrhea	☐ Dizziness
Respiratory	☐ Constipation	☐ Earaches
☐ Chronic cough	☐ Difficult digestion	☐ Sinus
☐ Shortness of breath	☐ Liver/gall bladder	☐ Neck pain
☐ Asthma	☐ Kidney/bladder	☐ Other:
☐ Bronchitis	**Muscle & Joint**	**Skin**
☐ Emphysema	☐ Pain	☐ Sensitive skin
☐ Other:	☐ Stiffness	☐ Rashes
Cardiovascular	☐ Swelling	☐ Acne
☐ High blood pressure	☐ Limited motion	☐ Cold sores
☐ Low blood pressure	☐ Fatigue	☐ Bruise easily
☐ Poor circulation	☐ Osteoarthritis	☐ Varicose veins
☐ Heart disease	☐ Rheumatoid arthritis	☐ Deep vein thrombosis
☐ Heart surgery	☐ Back pain	☐ Eczema/Psoriasis
☐ Pacemaker	◯ Upper ◯ Mid ◯ Lower	☐ Recent tattoos
☐ Stroke	☐ Shoulder pain	☐ Recent piercings
☐ Phlebitis	☐ Other:	☐ Stitches