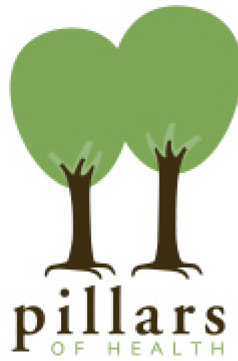


CONFIDENTIAL HEALTH HISTORY FORM

i) Personal Information

Date: ________ Name: ____

Age: ____ Sex: ____ Date of Birth (DD/MM/YYYY): ______________________________

Occupation: ________________ Address: ____

Phone number: _______________ E-mail address: __________________________________

Emergency contact name and number: ____

Family Doctor: _______________ How did you hear about us? ________________________

ii) Healthcare

Please circle all of the healthcare practitioners that you are currently attending treatment with:

Physiotherapist *Chiropractor* *Massage Therapist* *Dietician* *Naturopath*

Osteopath *Psychologist* *Acupuncturist* *Occupational Therapist*
Other: ____

Have you seen your family doctor and/or specialist about this problem? ____________

Have you obtained (related to what you are seeking treatment for):

X-Rays CT Scan MRI Blood Tests

Other Tests: ____

If so, the result(s)? ____

Please list any medications, vitamins, and/or supplements you are currently taking and their purpose:

Allergies:

Have you ever been hospitalized, had any major accidents, illnesses or surgeries or complications:

Family Health History:

iii) Current Condition

Present Chief Complaint(s) (reason for seeking treatment):

Please briefly describe your condition and symptoms:

On a scale of 1-10, with 10 being the highest, what is your current pain level?

How long have you had this condition?

How did it start?

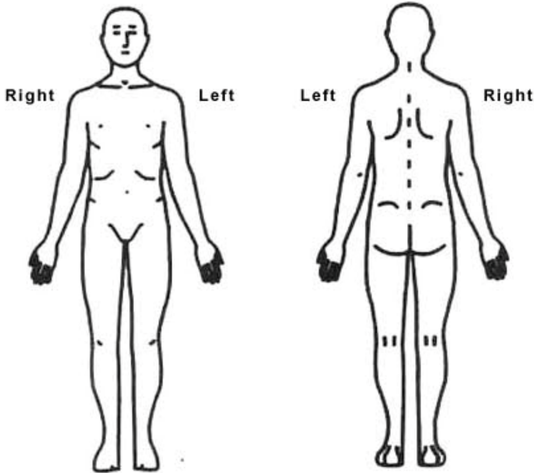
Goals (What would you like to achieve from treatment):

What positions / activities most aggravate your condition?

What position is the most comfortable for you to be in? What offers relief?

What activities (if any) are you currently prevented from doing because of your symptom(s)?

Please indicate on the diagram the location of your symptoms:



How would you characterize the sensation?

□ dull/achy □ sharp/stabbing □ burning
□ tingling /numbness □ electrical □ continuous
□ comes and goes □ fixed location
□ moves around □ shooting/ radiating

iv) Medical History

Please mark 'C' for current and 'P' for past

CARDIOVASCULAR

( ) High Blood Pressure ( ) Low Blood Pressure ( ) Palpitation
( ) Heart Attack ( ) Heart Disease ( ) Stroke
( ) Angina ( ) Varicose Veins ( ) CCHF
( ) Poor Circulation ( ) Murmur ( ) Dizziness
( )Pace Maker ( ) Aneurysm ( ) OTHER: ___________________

NEUROLOGICAL

( ) Multiple Sclerosis ( ) Parkinson's Disease ( ) Cerebral Palsy
( ) Epilepsy ( ) SCI ( ) Loss of or Altered Sensation
( ) OTHER: ___________________

RESPIRATORY

( ) Asthma ( ) Emphysema ( ) Bronchitis
( ) Chronic Cough ( ) Difficulty Breathing ( ) OTHER: ____________________

GASTROINTESTINAL

( ) Constipation ( ) Diarrhea ( ) Irritable Bowel Syndrome
( ) Ulcers ( ) Crohn's Disease ( ) Colitis
( ) Hernia ( )OTHER: _____________________

OTHER

( ) Allergies ( ) Diabetes ( ) Cancer
( ) Fainting ( ) Fever ( ) Insomnia
( ) Stress ( ) Headaches ( ) Painful Menstruation
( ) Hepatitis ( ) HIV / AIDS ( ) Tinnitus
( ) Thyroid disorder ( ) Arthritis ( ) Skin condition
( ) Bladder condition ( ) Prostatitis ( ) Sexual dysfunction
( ) Sinusits ( ) OTHER: ___________________

v) Lifestyle

How would you rate your energy level on a scale of 1-10, with 10 being the highest: _____

How would you rate your stress level on a scale of 1-10, with 10 being the highest: _____

How many hours of sleep do you get each night? ______________

Do you experience: □ Difficulty falling asleep □ Staying asleep □ Interrupted sleep □ Nightmares □ Vivid dreams □ Wake up not well-rested

Level of physical activity? What and how frequent?

____

Do you do any of the following: □ Smoke □ Consume Alcohol □ Recreational drugs

How much water do you consume in a day? ___________________

Women

Are you currently pregnant? ___________ Have you been pregnant previously? __________

Have you given child birth previously? __________

vi) Cancellation Notice and Privacy Consent

Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours' notice of cancellation, or a cancellation fee of 50% of your service price will be charged.

Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient and to be paid prior to service rendered. Your extended healthcare insurance plan may cover all or a portion of your treatment, however plans vary considerably so please check with your provider regarding your coverage.

Any documentation requested by the patient or third party, such as an insurance company, will be charged a reasonable fee determined based on case to case.

I understand that my personal information is being stored on a secure online web application. Other associates may access the secure online information as pertains to my circle of care if necessary.

I authorize the clinic and its associated practitioners to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments via phone call, e-mail or text message.

In addition, I authorize the clinic and its associated therapist to communicate with my MD or amongst other therapist(s) at Pillars of Health, as deemed necessary for my beneficial treatment.

I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

* Your choices regarding your healthcare should be informed and voluntary. In order to provide you with the most effective and safe treatment, it is important that you are active in your own care and provide your therapist with feedback. All records are confidential unless otherwise requested with your authorization.

I consent to the above Cancellation and Privacy Notice: Yes ☐ No ☐

Patient signature: ____

(Parent/Guardian required to sign if under the age of 18)

Date of signature: ____

Practitioner signature: ____