HEALTH HISTORY FORM

All information is confidential

Name:	Home Phone:
Mailing Adress:	Work Phone:
	Height:
	Weight:
Date Of Birth	Referred by:
Occupation:	General Practitioner:

email: _____

CURRENT HEALTH

☐ I am here for my health and well being, not for any particular concern.

☐ I am here for my general health & well being, and for a specific concern / cond

My major are of pain / concern is:_____
A secondary area of Pain / concern is:_____
The length of time I have had these conditions:_____
The condition was brought on by:_____
Specific diagnosis or assessment I have received:_____
The diagnosis was made by (name)_____

The pain / discomfort is:

☐ Constant
☐ Comes and Goes
☐ Getting Better
☐ Getting Worse
☐ Interferes with work
☐ Interferes with my daily routine
☐ Disrupts sleep
☐ Is relieved by:_____
☐ Is Aggravated by:_____
☐ Familiar – I have had a similar condition before

LIFESTYLE

	Never	Occasionally	Weekly	Daily		Never	Occasionally	Weekly	Daily
Cigarettes	☐	☐	☐	☐	Meditation	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	Yoga	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐	Stress	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Sound	☐	☐	☐	☐
Fun	☐	☐	☐	☐	Sleep				

I Have / use:

- ☐ Artificial limb / joint
- ☐ Eyeglasses
- ☐ Back Brace
- ☐ Contact Lenses
- ☐ Metal Plate
- ☐ Dentures
- ☐ Pacemaker
- ☐ Cosmetic implant

☐ I am currently taking medication

Type:	Reason Fro Use:

Treatments I am currently receiving:

	Practioner	Frequency of Treatments
Massage Therapy		
Acupuncture		
Physiotherapy		
Osteopathy		
Chiropractic		
Homeopathy		
Other:		

Health History
(I have had or have presently)

- ☐ Poor Circulation
- ☐ Stroke
- ☐ Hemophilia
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Varicose Veins
- ☐ Chest Pain
- ☐ Dissiness
- ☐ Congestive heart failure
- ☐ Loss of Sensation
- ☐ Headache
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Difficulty Breathing
- ☐ Chronic Cough
  - ☐ Skin irritation
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stomach/bowel pain
- ☐ Urinary Problems
- ☐ Hearing / Vision
- ☐ Osteoarthritis
- ☐ Osteporosis
- ☐ Phlebitis
- ☐ TMJ Pain / Dysfuntion
- ☐ Multiple Sclerosis
- ☐ Epilepsy
  - ☐ Diabeties
- ☐ Hepatitis
  - ☐ Cancer
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Endometriosis
- ☐ Pelvic Inflammation
- ☐ Muscle Weakness
- ☐ Muscle Soreness
  - ☐ Loss of Appetite
- ☐ Weight Gain
- ☐ Infectious skin
  - ☐ Allergies / Other

History of Injury or Surgery

Please list any surgery, motor vehicle accident, Including approximate dates.

Injury / Surgery	Date:	Treatments Received

Consent

I,_____ have fully reviewed the Client Health History Form and have truthfully and accurately detailed my previous and current health status. I understand that my practitioner must be made aware of any existing physical conditions, and I agree to keep my practitioner informed of any changes in my health status for my records. I consent to receive osteopathy/ massage therapy / and or exercise rehabilitative services. *Please circle the applicable treatment(s). Thank you.*

I understand that the information about my injuries as well as subsequent treatments will be sent to my physician. I hereby authorize G.E.T. Back Rehabilitation to release information regarding my current condition and progress, my treatment, and my ability to return to normal activities, to my physician.

I am aware that I must give twenty-four hours notice before canceling an appointment, or I will be held financially accountable for 100% of the fee for that session. I am also aware that this charge will be sent to me directly, and to my health plan. Three missed appointments will result in discharge and notification to my insurer.

_____ _____

Signature Date

Health History Update
(To be filled in by Health Practitioner only)

Over →

HOW DID YOU CHOOSE US

- Physician Recommendation
- Internet/Google Search
- Advertisement
- Family and Friends Recommendation
- Telephone Directory
- Location
- Other

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