In Good Hands

MEDICAL HISTORY FORM

Last Name:_____First Name:_____

Date of Birth (DD/MM/YYYY)_____Age:_____

Email: _____Preferred Phone: _____

Address:_____

_____Postal Code:_____

How did you hear about the clinic? _____

Family Doctor: _____ Phone:_____

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY. THE INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON OR ORGANIZATION, EXCEPT FOLLOWING YOUR WRITTEN AUTHORIZATION. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

Other health care providers you have received treatment from (past or present):

Name:_____Designation:_____

Name:_____Designation:_____

Name:_____Designation:_____

Please list the health concerns that brings you to In Good Hands:

_____

_____

Have you consulted any other medical specialists in the past year, if so who? Any images taken the past year? **(MRI, CT-Scan, X-Ray, Ultra-Sound, indicate month)**

_____

_____

Date of your last physical exam: _____

Past surgeries or procedures: 1) _____Year_____

2) _____ Year _____ / 3) _____Year _____

4) _____ Year _____ / 5) _____ Year _____

If you are female, are you currently pregnant: YES NO

Please list all your CURRENT medications:

Medication	Dosage	How long taken	Reason for use

Please list any "over the counter" medications you are presently taking (e.g. Aspirin, Tums)

Medication	Dosage	How long/often taken	Reason for use

Please list any vitamins, minerals, herbs or homeopathic remedies you take on a regular basis:

Supplement	Dosage	How long taken	Reason for use

Please list all sensitivities / allergies / reactions to the following:

Drugs: _____

Environment: _____

Food: _____

Personal Health Habits:

Do you exercise regularly? **Y** or **N** Type:_____

How many hours of sleep do you get per night? _____ Do you feel rested: **Y** or **N**

Problems falling or staying asleep? **Y** or **N.** Wake up at specific times during the night? **Y** or **N**

How much fluids total do you drink in a day? _____ Amount of water/day_____

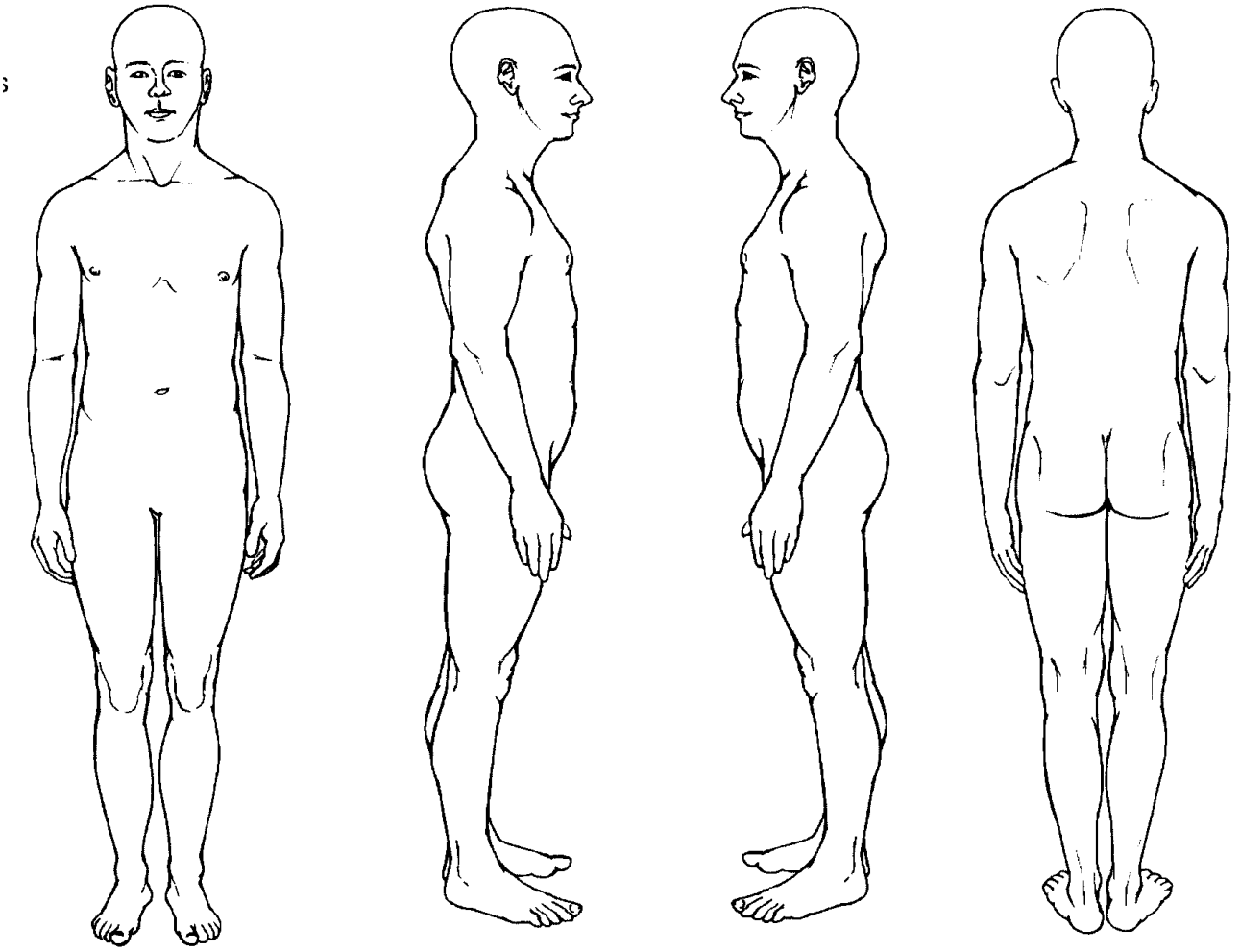
Circle your overall stress levels: Low Average High Very high Unbearable

Please print a "C" for all CURRENT conditions and "P" for all PAST conditions where applicable:

General	Muscle and Joints	Respiratory	Gastrointestinal
Headaches ____	Neck ____	Asthma ____	Heartburn ____
Migraines ____	Upper back ____	Sinus problems ____	Nausea ____
Dizziness ____	Mid back ____	Emphysema ____	Change in appetite ____
Head injury ____	Lower back ____	Chronic Cough ____	Abdominal pain ____
Insomnia ____	Painful tailbone ____	Chest pain ____	Indigestion ____
Chronic Fatigue ____	Shoulder pain ____	Bronchitis ____	Diarrhea ____
Numbness/Tingling ____	Elbow / Wrist pain ____	Pneumonia ____	Constipation ____
Anxiety / Depression ____	Hand pain ____	Pleurisy ____	Blood in stools ____
Fibromyalgia ____	Hip pain ____	Difficulty breathing ____	Hemorrhoids ____
Weight loss / gain ____	Knee pain ____	Frequent colds ____	Jaundice ____
Hyper/Hypoglycemia ____	Ankle pain ____	Hay fever ____	Liver disease ____
Genitourinary problems___	Foot pain ____	**Cardiovascular**	Gallbladder disease ____
Hepatitis A / B / C ____	Jaw pain ____	High blood pressure ____	Hiatus hernia ____
Edema ____	Arthritis ____	Low blood pressure ____	Ulcers ____
Cancer ____	**Female**	Heart attack ____	IBS/Colitis/Crohn;s _____
Herpes / HIV____	Painful menses ____	Stroke / TIA ____	**Male**
Diabetes____	Endometriosis ____	Angina / Chest Pain ____	Hernia ____
Epilepsy____	Hormone therapy ___	Congestive Heart Failure__	Prostrate problem ____
Hyper/Hypothyroidism___	Number of pregnancies___	Heart attack __Year_____	Testicular pain ____
Tuberculosis____	Irregular cycle ____	Varicose Veins/Phlebitis__	Testicular mass____
Rashes / eczema____	Painful intercourse ____	Pacemaker ____	Impotence _____
Psoriasis / Warts____	Menopausal _____	Other: _____	Other: _____

Please list any other relevant health / personal information that you feel is missing such as work-related injuries, older surgeries, falls or motor vehicle accidents & date

Pain – **XXXX** Stiffness - *////* Numbness/Tingling – 0000 Other (specify)_____



I have stated all medical conditions that I am aware of and will update my therapist of any changes in my health status.

Client Signature: _____

Date:_____