Medical History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

PLEASE PRINT

Name: ______________________ **Cell #** ____________ (Home) ____________ (Work) ____________

Address: ______________________ **City:** ____________ **Postal Code:** ________

Date of Birth: ____________ Occupation: ________________ Source of referral ____________

What is your chief complaint? ____________________ **Email** ____________________

Name of your Insurance Company: ______________________________

Please indicate conditions you are experiencing or have experienced:

HEAD

- ❑ headaches
- ❑ migraines
- ❑ vision problems/loss
- ❑ earaches/hearing loss
- ❑ jaw problems

RESPIRATORY

- ❑ smoking
- ❑ chronic cough
- ❑ emphysema
- ❑ asthma
- ❑ bronchitis
- ❑ shortness of breath

CARDIOVASCULAR

- ❑ high blood pressure
- ❑ low blood pressure
- ❑ chronic congestive heart failure
- ❑ history of heart disease/MI
- ❑ phlebitis/varicose veins
- ❑ stroke/CVA
- ❑ pacemaker or similar device
- ❑ heart attack
- ❑ other: ______________

WOMEN

- ❑ pregnant, due: __________
- ❑ gynecological conditions ______________

MUSCLES/JOINTS

- ❑ neck
- ❑ mid-back
- ❑ lower back
- ❑ shoulders L or R
- ❑ legs L or R
- ❑ other: ______________

INFECTIONS
(Hepatitis, TB, HIV, AIDS and other)

____

SKIN CONDITIONS

____

SURGERY

type: ______________
date: ______________
current symptoms: __________

INJURY

type: ______________
date: ______________
current symptoms: __________

OTHER CONDITIONS

- ❑ digestive problems
- ❑ constipation
- ❑ epilepsy
- ❑ loss of sensation
- ❑ liver/gall bladder problems
- ❑ kidney problems
- ❑ diabetes
- ❑ allergies/hypersensitivity reaction
- ❑ cancer
- ❑ arthritis
- ❑ hemophilia
- ❑ osteoporosis
- ❑ mental illness
- ❑ internal pins, wires, artificial joints or special equipment

where? ______________
- ❑ other: ______________

CURRENT MEDICATION

name use

____

____

MEDICAL DOCTOR

Name: ______________

Date of Medical History:
Update 1:
Update 2:
Update 3:
Update 4:

I understand that the information I give on this form will be confidential and will be used for no other purpose than medical professional's clinical records. The information given by me on this form is accurate to the best of my knowledge, and I understand that will be used by the medical professional in determination of treatment which is appropriate for me. It is my responsibility to update this information as it changes.

Date: ______________________ Signature: ______________________

CONSENT TO OSTEOPATHIC & MASSAGE THERAPY

I ____ give my consent to be given Osteopathic and Massage Therapy for the following complaint(s): ____
____

The therapist has provided me with information relevant to treatment for the above-listed complaint(s).
Alternative courses of treatment where applicable and relevant as well as the possible risks and side effects of my therapist's proposed treatment plan, have been explained to me.
The consequences of having treatment / not having treatment have been explained to me.
I have been informed that I may stop treatment at any time.
At any given time throughout the treatment, I may request the therapist to stop, modify or change the treatment plan.

I have read the above and understand the consent to Osteopathic and Massage Therapy.

Date: ___________________________________ Patient's signature: ___________________________