Health History
Update 1 _____
2 _____
3 _____
4 _____

MARSDEN WELLNESS CENTRE
Osteopathic Manual Therapy • Massage Therapy

Date: _____

CONFIDENTIAL CASE HISTORY

Name: _____ Date of Birth: _____
Address: _____ Tel. # (H): _____
_____ Tel. # (C): _____
Occupation: _____ Email: _____
Doctor: _____ Dr. Tel. #: _____
Address: _____

How did you hear of us? MD ☐ Newspaper ☐ Yellow Pages ☐ Friend ☐ Other _____
Have you had manual therapy in the past? *Yes ☐ No ☐ *(example: massage therapy, physiotherapy, osteopathy)
Please check if you are currently seeing: MD ☐ Chiropractor ☐ Physiotherapist ☐ Psychotherapist/Counselor ☐
Naturopath ☐ Homeopath ☐ Massage Therapist ☐ Osteopath ☐ Other _____

How is your general health? _____

GENERAL HEALTH HISTORY: Please check the applicable boxes.

Head/Neck:
- ☐ headaches-frequency _____
  type: _____
- ☐ vision problems
- ☐ vision loss
- ☐ contact lenses
- ☐ hearing loss/impairment
- ☐ ear problems
- ☐ fainting
- ☐ epilepsy
- ☐ sinus
- ☐ dizziness/vertigo
- ☐ whiplash date: _____
- ☐ loss of consciousness/concussion
- ☐ cataracts
- ☐ hearing aid
- ☐ head trauma
- ☐ TMJ/jaw problems

Respiratory:
- ☐ chronic cough
- ☐ shortness of breath
- ☐ asthma
- ☐ bronchitis
- ☐ emphysema
- ☐ pneumonia
- ☐ family history

Trauma:
- ☐ stress at work or home
- ☐ fractures _____
- ☐ sprains _____
- ☐ sports injuries _____
- ☐ MVA _____
- ☐ significant fall
- ☐ other injuries _____
  _____

Cardiovascular:
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ poor circulation
- ☐ swelling/edema
- ☐ heart disease
- ☐ hypoglycemia
- ☐ hardening arteries
- ☐ stroke/CVA
- ☐ hemophilia
- ☐ varicose veins/phlebitis
- ☐ chronic congestive heart failure
- ☐ pacemaker
- ☐ heart attack
- ☐ family history of heart problems

  _____
  _____

Skin:
- ☐ sensitive skin
- ☐ rashes/eruptions
- ☐ herpes
- ☐ phlebitis
- ☐ bruise easily
- ☐ infectious skin conditions
- ☐ other skin disorders

  _____

Digestive/Uro-gential:
- ☐ poor appetite ☐ difficult digestion
- ☐ constipation/diarrhea
- ☐ gas/burping
- ☐ liver/gall bladder
- ☐ kidney/bladder
- ☐ diabetes onset _____
- ☐ ulcers
- ☐ other _____

Women:
- ☐ pregnant due: _____
- __ number of pregnancies
- ☐ menopause

menstruation:
- ☐ painful ☐ heavy ☐ scant
- ☐ gynecological conditions:

  _____
  _____

PLEASE TURN OVER →

Other:

☐ orthotics
☐ rheumatoid arthritis _____
☐ seizures
☐ MS
☐ osteoarthritis _____
☐ hepatitis
☐ osteoporosis
☐ scars _____
☐ HIV
☐ fatigue
☐ TB
☐ alzheimers
☐ insomnia
☐ chronic fatigue syndrome
☐ fibromyalgia
☐ depression
☐ loss of sensation _____
☐ Parkinsons
☐ anxiety
☐ allergies - please list: _____
☐ cancer - type: _____
☐ Other diagnosed diseases/medical conditions: _____
☐ previous surgery - type: _____ Date: _____
_____ Date: _____
_____ Date: _____
☐ pins, wires, plates, artificial joints:
location: _____
☐ dentures/oral appliance/partial plate

Current Medications *(including aspirin, ibuprofin):*

Name: _____ Conditions Treated: _____
_____ _____
_____ _____
_____ _____

Please check what accurately describes your use of the following:

	Regular	Occasional	Never
Tobacco	☐	☐	☐
Alcohol	☐	☐	☐
Caffeine	☐	☐	☐

Exercise (regularly i/e 3x wk) ☐ yes ☐ no type _____

Current Concern:

Location of current concern? _____

How long have you had this concern/injury? _____

What has caused this concern/injury? _____

Please check the boxes which describe the qualities of your pain:

☐ sharp ☐ shooting ☐ burning ☐ aching ☐ dull ☐ throbbing
☐ deep ☐ superficial ☐ poorly localized ☐ well localized
☐ constant ☐ intermittent ☐ brief, transient

Please indicate on the scale where you feel your current level of pain lies:

No pain /--------/--------/--------/--------/--------/--------/--------/--------/--------/--------/ Worst Pain Imaginable
0 1 2 3 4 5 6 7 8 9 10

What increases your pain? _____

What relieves your pain? _____

- The information on this form is complete and accurate to the best of my knowledge and I will update my therapist of any changes in my health status.
- I understand that the information given on this form is confidential and will be used only for the therapist's clinical records; there will be no release of this information to anyone without written authorization from me.
- It is my responsibility to communicate with the therapist. I understand that during the course of treatment I am encouraged and have the right to ask questions about procedure or effects of my treatment. At any time before or during, I can ask the therapist to alter or stop the course of treatment.
- *24 hours notice is required for cancellation of my appointment.*
  I understand there will be a charge for a missed appointment or late cancellation. ☐ INITIAL
- I hereby give my consent to treatment.

Signature: _____ Date: _____