



ELEMENTS OSTEOPATHY
313 MAIN ST. EAST UNIT #11
KINGSVILLE, ON N9Y1A7
519 733-1000 elementsosteo@outlook.com

Please fill out this form as completely and accurately as possible. A complete and accurate health history is important to ensure the appropriate care and treatment plan can be given. All information gathered will remain private and confidential except for that which is required by law. If information is to be shared with other health care providers, your written permission will be required.

Name: _____ Date: _____
Address: _____ Postal Code: _____
Phone: (H) _____ Email: _____
(B) _____ Family Physician : _____
(C) _____ Physician's Phone : _____
Date of Birth: _____ Occupation: _____
Other Health Care Providers: _____
Surgery/Injury: _____ Date: _____
Current Medication: _____
Condition it treats: _____
Extended Health Care Provider and policy #: _____
Do you have a work related injury?: _____ WSIB Claim #: _____
Are your injuries a result of a motor vehicle accident?: _____
How did you hear about the clinic? _____

Please indicate if you have or are experiencing any of the following conditions.

**Respiratory/
Circulation**

- chronic cough
- shortness of breath
- bronchitis
- asthma
- emphysema
- sinus problems
- allergies
- varicose veins
- lymphedema
- poor circulation
- phlebitis/DVT
- other _____

Nervous System

- MS
- epilepsy
- numbness/tingling
- paralysis
- spinal cord injury
- head injury
- concussion

Cardiovascular

- heart disease
- CCHF
- prev.heart attack
- pace maker
- stroke/CVA
- high blood pressure
- low blood pressure
- blood clots
- high cholesterol

Soft Tissue/Skeletal

- spasms/cramps
- fibromyalgia
- tension headaches
- strains/sprains
- tendonitis
- arthritis
- osteoporosis
- scoliosis
- fracture
- bone/joint disease
- jaw/TMJ pain
- herniated disc _____

Skin

- rash
- athlete's foot
- warts
- moles
- herpes/shingles

Infections

- HIV
- hepatitis Type _____
- Tuberculosis
- skin infection

Digestive/Urogenital

- diarrhea/constipation
- hernia Type _____
- ulcers
- acid reflux/heartburn
- kidney stones
- gallbladder
- liver

- urinary bladder
- prostate

Gynecological

- pregnant due: _____
- hysterectomy
- menopause problem
- menstrual problem
- other (specify) _____

Other

- vision loss/glasses
- hearing loss/hearing aid
- diabetes Type _____
- thyroid
- cancer Type _____
- migraine headache
- pins/wires/artificial joints
- autoimmune disorders

Use of;

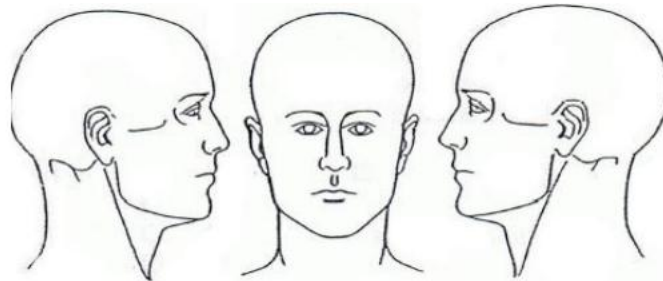
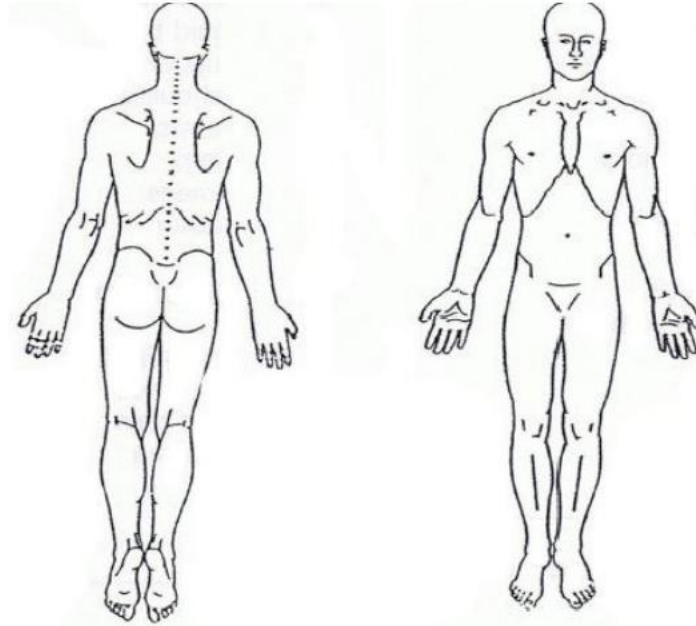
- alcohol; mild moderate heavy
- tobacco; #per day _____
- CBD/THC; mild moderate heavy

**Please list any
additional information:**

HEALTH HISTORY FORM CONT'

What is your primary concern? _____

Please mark problem/painful areas: "p"- pain "a"-aching "r"-radiating "n" numb/tingling "s" muscle/joint stiffness



Do you have limitation of movement and/or inflammation? Please explain:

I acknowledge the facts given on this health history form are accurate and complete. If there are any changes in the future I accept full responsibility to inform the Osteopathic Practitioner. I understand that the information provided is kept private and confidential but may need to be shared with other Health Care Providers. I understand that by signing this disclosure statement I agree to the release of my information and clinical chart as needed or required by law. I am aware there is a fee for cancelled or missed appointments without 24hrs notice.

Signature _____ Date: _____