Body Solutions
NEURO-FUNCTIONAL HEALTH CLINIC

Health History Form

Please fill out in full.

An accurate health history is important in assisting your therapist to treat you safely. If your health status changes in the future, please let your therapist know. All information gathered for this and future treatments are confidential, except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Date:

Last Name (print): ____________ **First/Given Name(s)** (print): ____________ **Email** ____________

Address: ____________ **Apt.#** ______ **City** ____________ **Postal Code** ____________

Home No. (___) ____________ **Work No.** (___) ____________ **Mobile No.** (___) ____________

Date of Birth: ________ **Weight:** ______ **Height:** ______ **Occupation:** ____________ **# of years:** ____________

Do you have any personal or work coverage / extended insurance? ☐ Yes ☐ No

How did you hear about our practice? ☐ friend (name): ____________ ☐ doctor (name): ____________

☐ web site ☐ article ☐ promotional item/advertisement ☐ other: ____________

Health History: Please check the conditions that you are currently experiencing, or have experienced often in the past and write FHx for family history. Though they may seem unrelated for the purpose of your appointment, these conditions may affect the course of your care.

Current	Previous	**Head/Neck**
☐	☐	headaches
☐	☐	migraines
☐	☐	glasses / contacts
☐	☐	ringing in ears
☐	☐	clumsiness /dizziness jaw pain/ TMJ/ grind/ clench teeth
☐	☐	whiplash
☐	☐	other: ____________

Current	Previous	**Skin**
☐	☐	bruise easily
☐	☐	eczema / psoriasis
☐	☐	warts
☐	☐	rashes

Current	Previous	**Respiratory**
☐	☐	shortness of breath
☐	☐	smoking
☐	☐	asthma
☐	☐	bronchitis
☐	☐	other: ____________

Current	Previous	**Cardiovascular**
☐	☐	high/low blood pressure
☐	☐	anemia
☐	☐	heart disease
☐	☐	stroke
☐	☐	deep vein thrombosis
☐	☐	hardening of arteries
☐	☐	pacemaker
☐	☐	bleeding disorder
☐	☐	other: ____________

Current	Previous	**Other Conditions**
☐	☐	cancer
☐	☐	depression
☐	☐	constipation/heartburn
☐	☐	concussion
☐	☐	intestinal/IBS
☐	☐	kidney
☐	☐	bladder
☐	☐	carpal tunnel syndrome
☐	☐	fibromyalgia / chronic fatigue
☐	☐	cysts (type)
☐	☐	other: ____________

Current	Previous	**Diabetes**
☐	☐	onset ____________
☐	☐	**Osteoporosis**
☐	☐	arthritis: oster RH
☐	☐	other: ____________
		Spine
☐	☐	scoliosis c / s curve
☐	☐	spondylolisthesis (forward slipping of vertebrae)
☐	☐	herniated intervertebral disk: ____________
☐	☐	degenerating discs: ____________
☐	☐	spinal fusion
		location: ____________
		date: ____________

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Georgetown, ON L7G 4P4
bodysolutionshc.org

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Please fill out in full.

Current	Previous	**Infections**
☐	☐	Herpes
☐	☐	Hepatitis
☐	☐	HIV, AIDS
☐	☐	TB
		Women
☐	☐	menstrual problems
☐	☐	pregnant? due: ______
☐	☐	children: no#: ______
☐	☐	caesarean section, or other gynaecological
☐	☐	painful menstruation
☐	☐	menopausal problems
☐	☐	miscarriages: #
☐	☐	endometriosis
☐	☐	incontinence ☐ bladder ☐ rectal
☐	☐	other: ______
☐	☐	______
☐	☐	______

Surgery

type & emergency care ______

date: ______

other: ______ location ______ date: ______

other: ______ location ______ date: ______

other: ______ location ______ date: ______

☐ wisdom teeth ☐ bridges date: ______

☐ appendix ☐ gallbladder date: ______

☐ whiplash ☐ concussion ☐ accident(s) (ie. car, falls) date: ______

☐ broken bones/ sprains/ tears/ dislocations ☐ other date: ______

Current Medications

	Current Medications	Condition It Treats
☐	Pain Killers	______
☐	Anti-inflam	______
☐	Muscle Relaxant	______
☐	Anti-coagulant	______
☐	Other:	______

Medical Doctor

Name: ______

Phone: (__) ______

Address: ______

May contact if necessary? ☐ Yes ☐ No

Current	Previous	**Other Health Care Providers:**
☐	☐	Massage ______
☐	☐	Chiropractic ______
☐	☐	Physiotherapy ______
☐	☐	Acupuncture ______
☐	☐	Osteopathy ______
☐	☐	Psychotherapy ______
☐	☐	Other: ______

OF SPECIAL NOTE Please check any of the following:

☐ pins ☐ wires ☐ artificial joints or limbs

ACTIVITIES OF DAILY LIVING

Occupation (present): ______ past: ______

☐ Computer ☐ Sit a lot (drive/desk) ☐ On feet all day ☐ Lift heavy objects ☐ Repetitive movements: ☐ Other: ______

Water/day: ☐ 2L ☐ 1L ☐ Filtered? ☐ I don't like water **Nutrition:** ☐ fresh fruits/vegetables ☐ processed meat ☐ fast food

Lighting Exposure: ☐ mainly outdoor ☐ mainly indoor ☐ both ☐ florescent/new energy saver

Recreation (e.g. sports): ☐ stretch ☐ min/day ☐ walking ☐ running ☐ cycling ☐ golf ☐ hockey ☐ football ☐ racquet sports

☐ swimming ☐ other: ______ **Frequency per week:** ☐ 5-7days ☐ 3-5 days ☐ 1-2 days ☐ infrequent

Hobbies ☐ reading ☐ play musical instrument ☐ photography ☐ knitting ☐ painting ☐ other: ______

Support Equipment ☐ wear orthotics ☐ brace ☐ walker ☐ cane ☐ other: ______

Sleep Patterns ☐ wake up often ☐ constant toss/turn ☐ sound ☐ stomach ☐ back ☐ side ☐ pillow support

Handed: ☐ R ☐ L