Body Solutions
NEURO-FUNCTIONAL HEALTH CLINIC

HEALTH HISTORY FORM - (Must be filled in full, please.)

Date: m/d/y _____20__ Updated: _____20__ ; _____20__ ; _____20__ ;

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.

Last Name (print): _____ **First/Given Name(s)** (print): _____ ☎( )_____x____ Work

Address:_____ Apt.#_____ _____ _____ ☎( )_____x____
Number / Street | City | Postal Code | Home

✉ **email:** _____

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

		Respiratory
☐	☐	shortness of breath
☐	☐	smoking
☐	☐	asthma
☐	☐	bronchitis
☐	☐	other: _____

		Cardiovascular
☐	☐	high/low blood pressure
☐	☐	anaemia
☐	☐	heart disease
☐	☐	stroke: _____
☐	☐	deep vein thrombosis
☐	☐	hardening of arteries
☐	☐	pacemaker
☐	☐	bleeding disorder:_____
☐	☐	other: _____

Medical Doctor
Name:_____
Phone:( )_____
Address:_____

May the therapist contact if necessary?
☐ yes ☐ no

Other Health Care Providers:
☐ Massage ☐ Chiropractic
☐ Physiotherapy ☐ Acupuncture
☐ Osteopathy
☐ Psychotherapy: _____
☐ other: _____

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

Current	Previous	Infections
☐	☐	herpes
☐	☐	hepatitis
☐	☐	HIV, AIDS
☐	☐	TB
☐	☐	other_____

Current Medications

name	for what condition?
_____	_____
_____	_____
_____	_____

☐ Pain Killers ☐ Anti-inflam ☐ Muscle Relaxant
☐ Anti-coagulant

Other Conditions

cancer _____ type & emergency care:
_____
depression
Diabetes: onset _____
constipation / heart burn
intestinal / IBS_____
kidney _____
bladder _____
carpal tunnel syndrome
osteoporosis _____
arthritis: osteo / Rh
spine:
scoliosis c / s curve
spondylolisthesis (forward slipping of vertebrae): _____
herniated intervertebral disk: _____
degenerating discs: _____
fibromyalgia / chronic fatigue _____
spinal **fusion**: location: _____ **date**: _____
cysts: (type)_____
other: _____

Surgery/Injury

Date:
☐wisdom teeth/bridges _____
☐appendix ☐gallbladder _____
☐whiplash _____
☐concussion _____
☐accident(s) (ie. car, falls)_____
_____
_____
☐broken bones/sprains/tears/dislocations
_____
☐other: _____
_____

Women

pregnant? ☐ no ☐ yes; due:_____
children: ☐ no ☐ yes #: _____
☐ caesarean section, or other gynaecological surgery? _____
☐ ☐ miscarriages: # ____ ☐ family history
☐ ☐ menstrual problems
☐ ☐ painful
☐ ☐ menopausal problems
☐ ☐ endometriosis
☐ ☐ incontinence ☐bladder ☐rectal

OF SPECIAL NOTE: **circle if any:** pins, wires, artificial joints or limbs, **special equipment** e.g. walker, cane, etc. (For more space ⇨)