Thank you for carefully answering each question!

***Patient:** Blue ink,*
***Doctor:** Red ink*
***CA:** Green ink*

Thank you for choosing our facility. In our clinic we carefully examine all of the systems in your body so that we may gather all the information necessary in order to best address your healthcare and wellness. Please bear with us and all the paperwork we present to you. Please do not assume that any question is irrelevant or unimportant to your case, everything we ask here is highly relevant and extremely important! We need you to carefully and honestly answer every question so that we may piece together the best approach to managing your case.

Name:
Address:
Email: Phone:
DOB:

Check as many that apply to you about your reason for visiting us today:

☐ **Motor vehicle accident?** When did it occur?		☐ **Recent Fall?** When did it occur?	
☐ **Another type of accident, trauma, or injury:**	If yes, please answer the following: Please explain what the incident was; was it at work, home, or somewhere else?	☐ Less than 3 days old ☐ Between 8 wks & 4 months	☐ Between 3 days & 8 wks ☐ More than 4 months
☐ **Neurological problem or disease:**	If yes, please explain & include any prior diagnoses:		
☐ **Diagnostics:**	If yes, please explain what you think you are being treated and evaluated for:		

HxA-MVA
HxA-Fa
HxA-FN

Where you referred to us by another health care provider? ☐ No. ☐ Yes. If yes, who? _____

Are you currently taking any medications (prescribed or over the counter), if so please list them and include dosage? *(if more than 12 meds, please tell us & we will provide you with more paper!)*

1. _____. 5. _____. 9. _____.
2. _____. 6. _____. 10. _____.
3. _____. 7. _____. 11. _____.
4. _____. 8. _____. 12. _____.

Are you currently taking any herbs or nutritional supplements, if so please list them? *(if more than 12, please tell us!)*

1. _____. 5. _____. 9. _____.
2. _____. 6. _____. 10. _____.
3. _____. 7. _____. 11. _____.
4. _____. 8. _____. 12. _____.

Do you have any known allergies, if so please list them? *(if more than 6, please tell us!)*

1. _____. 2. _____. 3. _____.

If you have a Primary Complaint, please answer the following:

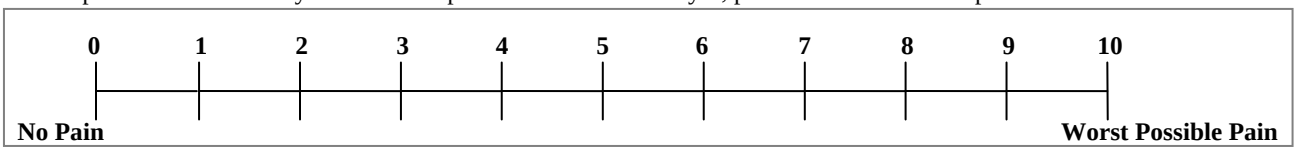
Doctor's Notes: _____

Doctor's Initials: _____

What is your primary complaint?_____

Is there pain associated with your chief complaint? ☐No. ☐Yes. If yes, please mark where that pain is on a scale of 1-10?

HxPnI_



Have you seen anyone else for this condition? ☐No. ☐Yes. If yes, who? _____

Have you lost work days for this condition? ☐No. ☐Yes. If yes, how much?_____

Have you tried any self-treatments for this condition?_____

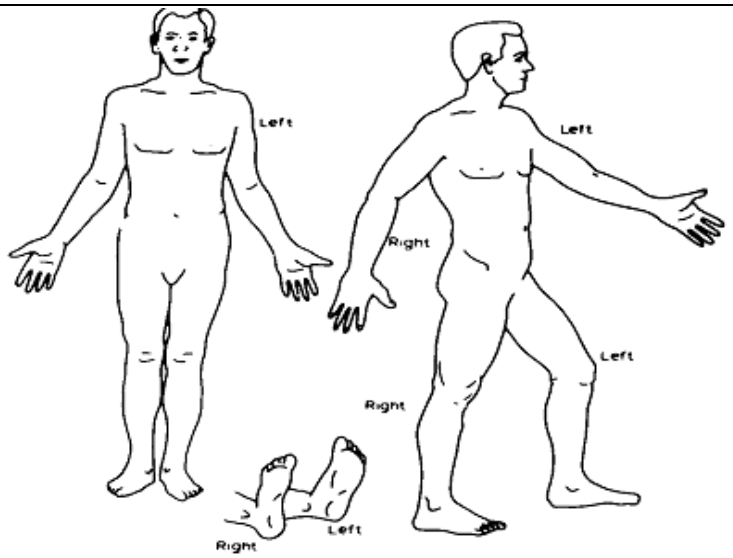
_____

Have you ever been treated for a similar problem, if so describe?_____

Do you have any other complaints or concerns?_____

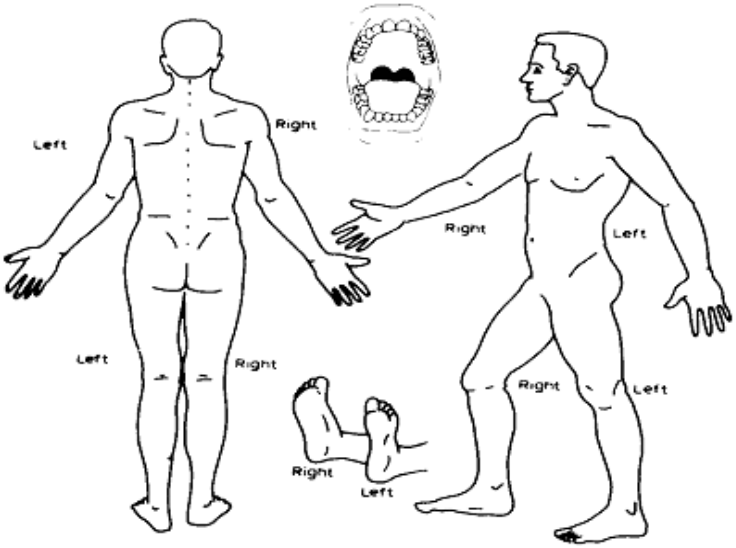
What do ***you*** think is causing your present health problem(s)?

On the diagram to the right, please mark the following symptoms, if you are experiencing them:
"//" for stabbing pain,
"**B**" for burning pain,
"**D**" for dull pain,
"**A**" for aching pain,
"**N**" or in areas where you have numbness
"**T**" in areas where you have tingling,
"**St**" in areas where you feel stiffness,
"**Sw**" in areas where you've had swelling,
"**C**" in areas where you have cramps,



Below indicate any ***other*** symptoms you think may be important.

_____
_____
_____
_____



What are your **5 greatest concerns** about your present state of health?

1. _____
2. _____
3. _____
4. _____
5. _____

Doctor's Notes:_____
_____
_____
_____

Doctor's Initials:_____

Please answer the following questions as completely as possible:

Please list all operations or surgeries you may have had with dates:_____

_____

Please list any hospitalizations you may have had with dates:_____

Please list any major illness you have had with dates:_____

Have you had any recent infections, colds, or flu? ☐No. ☐Yes:_____

Please list any and ***all*** traumas or injuries you've ever had, with dates, from the simple to the serious:_____

_____

_____

Have you ever been diagnosed with a tumor, cancer, neoplasia, or dysplasia? ☐No. ☐Yes:_____

Have you ever been diagnosed with diabetes? ☐No. ☐Yes:_____

Have you ever been diagnosed with a cardiac (heart) condition, a blood vessel condition (like arteriosclerosis, atherosclerosis, or vasculitis), or hypertension (high blood pressure)? ☐No. ☐Yes:_____

Have you ever had a stroke or heart attack? ☐No. ☐Yes:_____

Does anyone in your biological family (parent, grandparent, sibling, or child) have a history of heart disease, stroke, cancer, or diabetes? ☐No. ☐Yes, explain:_____

Does anyone in your biological family have a history of psychiatric diseases like depression, anxiety, schizophrenia, etc? ☐No. ☐Yes, explain:_____

Does anyone in your biological family have a history of neuropathies (nerve diseases) or myopathies (muscle diseases)? ☐No. ☐Yes, explain:_____

Does anyone in your biological family have a history of cancer? ☐No. ☐Yes, explain:_____

_____

Does anyone in your biological family have a history of back or neck pain? ☐No. ☐Yes, explain:_____

_____

Does anyone in your biological family have a history of any other known conditions? ☐No. ☐Yes, explain:_____

_____

_____

Please indicate your familial status? ☐Single. ☐Married. ☐Divorced. ☐Widowed.

How many children do you have? ☐None. ☐1. ☐2. ☐3. ☐4. ☐Other:_____.

What do you do for a living?_____. How many hours a week?_____

Do you have a second job?_____. How many hours a week?_____

Describe your work environment:_____

How long have you been at this job?_____What other jobs have you had in the past?_____

Describe your home life:_____

What is your highest level of education?_____. What are your hobbies?_____

Doctor's Notes:_____

_____

_____

_____

Doctor's Initials:_____

Do you exercise? ☐No. ☐Yes, then what type and how often:_____

Do you use any tobacco products? ☐No. ☐Yes, then what kind, how often, & how long:_____

Have you used tobacco products in the past? ☐No. ☐Yes, then what, how long, & when did you quit?_____

Do you drink alcoholic beverages? ☐No. ☐Yes, then what kind and how many a week:_____

Have you had alcohol problems in the past? ☐No. ☐Yes, then how long ago & for how long:_____

Do you drink caffeinated beverages? ☐No. ☐Yes, then what kind and how many a day:_____

Do you drink sodas? ☐No. ☐Yes, then how many a day:_____

Do you use recreational drugs? ☐No. ☐Yes, then how long ago & for how long::_____

Have you used recreational drugs in the past? ☐No. ☐Yes, then what type, when, & for how long:_____

Do you have any special dietary restrictions? ☐No. ☐Yes, then what type:_____

Are you sexually active? ☐No. ☐Yes. If yes have you ever been diagnosed with an STD or VD:_____

Review of Systems & Medical History:

1. Are you currently experiencing any of the following symptoms, now or recently?

☐ Chest pain	☐ Jaw pain	☐ Left arm pain
☐ Shortness of breath	☐ Excessive sweating without exertion	☐ Pale skin or pallor
☐ Blackouts	☐ Swelling in your left arm	☐ Lightheadedness

2. Please check off any of the below symptoms that you are be experiencing, now or recently?

☐ Nausea	☐ Vomiting	☐ Difficulty with speaking
☐ Dizziness or vertigo	☐ Difficulty with swallowing	☐ Disequilibrium or feeling unsteady
☐ Double vision	☐ Feeling like your are going to fall	☐ Abnormal eye movements
☐ Numbness	☐ Abnormal sweating	☐ Severe headache

R/F

3. Have you noticed any of the following?_____.

☐ Change in appetite ☐ Unexplained weight loss ☐ Unexplained weight gain ☐ Recent fever ☐ Recent fatigue

Please mark any of the below conditions that apply to you, past or present.

Condition	Past	Present	Condition	Past	Present	Condition	Past	Present	Condition	Past	Present
☐ Swollen or painful joints			☐ Foot or ankle pain			☐ Trouble with prolonged sitting or standing			☐ Herniated disc		
☐ Neck pain or stiffness			☐ Leg pain			☐ Trouble with walking			☐ Lumbago or lumbalgia		
☐ Upper back pain or stiffness			☐ Knee pain			☐ Trouble with bending, twisting, or lifting			☐ Scoliosis or other spinal curvature		
☐ Mid back pain or stiffness			☐ Shoulder pain			☐ Osteoporosis			☐ Difficulty walking		
☐ Low back pain or stiffness			☐ Elbow pain			☐ Dislocated bones			☐ Osteoarthritis or DJD		
☐ Hip or pelvis pain			☐ Arm pain			☐ Fractured bones			☐ Rheumatoid arthritis		
☐ Auto accidents			☐ Hand or wrist pain			☐ Bone infection (osteomyelitis)			☐ Other arthritis		
			☐ Jaw pain or click (TMJ)						☐ Gout		
			☐ Chronic headaches						☐ Ankylosing spondylitis		
			☐ Sprain or strain								
			☐ Sports injuries			☐ Machine accident			☐ Accidental fall		

HxA-Pn

HxA-mva
HxA-Fa

Doctor's Notes:_____

_____

_____

_____

Doctor's Initials:_____

Condition	Past	Present
☐ Migraines		
☐ Cluster headaches		
☐ Costen's syndrome		
☐ Balance problems		
☐ Mental or emotional disorder		
☐ Convulsions or epilepsy		
☐ Difficulty speaking		
☐ Difficulty swallowing		
☐ Losing time or blacking out		
☐ Changes in skin sensation		
☐ Muscle problems		
☐ Learning disability		
☐ Conduct disorder		
☐ Glaucoma		
☐ Dizziness		
☐ Motion sickness		
☐ Ear infections		
☐ Tinnitus		
☐ Sore throat		
☐ Pain in legs with movement or activity		
☐ Heart palpations (hearing racing heart)		
☐ Swelling in legs or feet		
☐ Congestive heart failure		
☐ Difficulty breathing		
☐ Chronic/frequent cough		
☐ COPD		
☐ Coughing up blood		
☐ Difficulty losing weight		
☐ Colon problems		
☐ Gall bladder trouble		
☐ Liver disease		
☐ Stomach/duodenal ulcer		
☐ Abdominal pain		
☐ Indigestion		
☐ Cirrhosis		
☐ Bloating		
☐ Craving sweets		
☐ Craving excessive salts		
☐ Pituitary disorder		
☐ Cold all the time		
☐ Dry skin		
☐ Change in hat size		
☐ Unexplained skin rash		
☐ Change in skin mole		
☐ Seborrhea		
☐ Acne		

Condition	Past	Present
☐ Trigeminal neuralgia or Tic Doloreaux		
☐ Hypertension headache		
☐ Seizures		
☐ Neurological disease		
☐ Trouble concentrating		
☐ Difficulty swallowing		
☐ Trouble understanding others		
☐ Stroke or CVA		
☐ Paralysis		
☐ Muscle weakness		
☐ Twitching muscles		
☐ Lost muscle tone		
☐ ADD or ADHD		
☐ Behavioral disorder		
☐ Macular degeneration		
☐ Vertigo		
☐ Unexplained giddiness		
☐ Ringing in ears		
☐ Sinus problems		
☐ Mouth sores		
☐ Heart attack (myocardial infarct)		
☐ Irregular heart beats		
☐ Experience passing out		
☐ Skipped heart beats		
☐ Congenital heart disease		
☐ Shortness of breath with activity		
☐ Short of breath at rest		
☐ Painful breathing		
☐ Hemorrhoids		
☐ Difficulty with control of bowel movements		
☐ Nausea &/or vomiting		
☐ Digestive problems		
☐ Constipation		
☐ Diarrhea		
☐ Polyps		
☐ Diverticulitis		
☐ Hormonal issues		
☐ Thyroid disorder		
☐ Adrenal disorder		
☐ Hot all the time		
☐ Trouble with sleep		
☐ Change in glove size		
☐ Itching		
☐ Change in nails		
☐ Eczema		
☐ Dermatitis		

Condition	Past	Present
☐ Tension headaches		
☐ Pain in your face		
☐ Temporal arteritis		
☐ Trouble sleeping		
☐ Difficulty with focus		
☐ Loss of memory		
☐ Fainting spells		
☐ Tire easily		
☐ Mini-stroke or TIA		
☐ Blurred vision		
☐ Double vision		
☐ Muscle cramping		
☐ Tremors (shaking)		
☐ Abnormal movements		
☐ Dyslexia		
☐ Asperger's syndrome		
☐ Cataracts		
☐ Unsteadiness		
☐ Difficult with balance		
☐ Earaches		
☐ Nose bleeds		
☐ Bleeding gums		
☐ Arrhythmia		
☐ Heart murmur		
☐ Atherosclerosis / arteriosclerosis		
☐ Dizzy or light-headed with exercise		
☐ Wheezing		
☐ Asthma		
☐ Coughing up mucus		
☐ Pneumothorax		
☐ Difficulty swallowing		
☐ Gall bladder stones		
☐ Intestinal issues		
☐ Heartburn		
☐ Gastric ulcers		
☐ Excessive belching		
☐ Digestive issues		
☐ Celiac Disease (Sprue)		
☐ Irritable bowel syndrm.		
☐ Night sweats		
☐ Decreased energy		
☐ Frequent urination		
☐ Hair loss		
☐ Increased sex drive		
☐ Under a lot of stress		
☐ Change in hair pattern		
☐ Bruise easy		
☐ Psoriasis		
☐ Skin cancer		

Condition	Past	Present
☐ Sinus headaches		
☐ Cervicogenic headaches		
☐ Other type of headache		
☐ Recent incoordination		
☐ Head seems heavy/tired		
☐ Head or arms feel tired		
☐ Loss of consciousness		
☐ Concussions		
☐ Head injury		
☐ Persistent headache		
☐ Spontaneous movement		
☐ Weak muscles of face		
☐ Numbness or tingling		
☐ Excessive sweating		
☐ Autism (PDD or ASD)		
☐ Bedwetting		
☐ Retinopathy		
☐ Pain with coughing or sneezing		
☐ Hearing loss		
☐ Difficulty swallowing		
☐ Hoarseness		
☐ High cholesterol		
☐ High blood pressure (hypertension)		
☐ Scarlet fever		
☐ Rheumatic fever		
☐ Other heart disease		
☐ Emphysema		
☐ Bronchitis		
☐ Snoring		
☐ Other lung problems		
☐ Hepatitis		
☐ More than 3 bowel movements a day		
☐ Less than 1 bowel movement a day		
☐ Excessive gas		
☐ Blood in stool		
☐ Ulcerative colitis		
☐ Crohn's disease		
☐ Diabetes		
☐ Hyperthyroidism		
☐ Hypothyroidism		
☐ Excessive thirst		
☐ Decreased sex drive		
☐ Change in skin color		
☐ Shingles		
☐ Herpes		
☐ Warts		
☐ Other skin disorder		

HxA-fn

HxA-GI

HxA-En

Doctor's Notes: _____

_____

_____

_____

Doctor's Initials: _____

Condition	Past	Present
☐ Psychological issues		
☐ Nervousness		
☐ Depression		
☐ Irritability		
☐ Prostate problems		
☐ Erectile dysfunction		
☐ Premature ejaculation		
☐ Problems with sexual libido or desire		
☐ Discharge from urethra		
☐ Gonorrhea		
☐ Bleeding disorder		
☐ Anemia		
☐ Allergies		
☐ The flu, how long ago _____		

Condition	Past	Present
☐ Anxiety		
☐ Feelings of hopelessness		
☐ Phobias		
☐ HPV / genital warts		
☐ PMS problems		
☐ Menstrual problems		
☐ Breast discharge		
☐ Vaginal discharge		
☐ Breast lumps / soreness		
☐ Menopause		
☐ Vascular disease		
☐ Varicose veins		
☐ Autoimmune disease		
☐ A cold, how long ago _____		

Condition	Past	Present
☐ Panic attacks		
☐ Mood changes		
☐ PTSD		
☐ OCD		
☐ Syphilis		
☐ Kidney problems or disease		
☐ Kidney stones		
☐ Difficulty urinating		
☐ Feelings of urgency to urinate		
☐ Leg pain with walking		
☐ Blood clots / phlebitis		
☐ Frequent colds or flues		
☐ Alcoholism		
☐ Cancer		

Condition	Past	Present
☐ Work or social stress		
☐ Anger easy		
☐ Feelings of suicide		
☐ Eating disorders		
☐ Infrequent urination		
☐ Blood in urine		
☐ Frequent urination		
☐ Painful urination		
☐ Awaken to urinate		
☐ Bladder infections		
☐ Other STD / VD		
☐ Venous insufficiency		
☐ Bruise easily		
☐ HIV / AIDS		
☐ Other:		

Past	Present

Hx-M/A

HxA-M
HxA-F

Females only:
Is there ***any*** possibility that you are currently pregnant? ☐No. ☐Yes.
What was the date of your last menstrual period?_____.

You may describe any other concerns or questions in this space below:

I understand that this clinic does not take any OCF-5 forms/cases.

"We are registered under Osteopathy. Osteopathy is unregulated in Ontario and insurance coverage is not guaranteed for brain based osteopathic rehab."

Thank you for taking the time to fill out this health history questionnaire. This information is important in the doctor obtaining a clinical picture so as to make an appropriate diagnosis & treatment plan. Please sign below authorizing that the information in this form has been read & filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered confidential & for use by your doctor. Any disclosure is outlined in our privacy policies.

_____Patient's signature (*or guardian's signature*)

_____Date

_____Signature of translator or person assisting with this form (*if any*)

Printed name of said person_____ _____Date

Doctor's Notes:_____

_____

_____

_____

Doctor's Initials:_____