Vancouver Osteopathy Centre

An accurate health history is important to ensure that it is safe for you to receive treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information. **Kindly note that 48 hours cancellation notice is required otherwise a missed appointment fee will be charged.**

Name: ______________________ Work #: __________ Home #: __________ Cell #: __________

Address: ______________________ City: __________ Postal Code: __________

Date of Birth: ___ / ___ / ___ Occupation: ______________________ ❑ Male ❑ Female

Primary Health Care Physician: ______________________ Physician's Tel # __________

Primary Complaint: ______________________

____

__________ Email Address: ______________________

General Health Status: ______________________

Investigations: XRAY / CT / MRI

____

Source of Referral: __________

Health History: Pease indicate ☑ conditions you are experiencing or have experienced.

SOFT TISSUE/JOINTS
(Specify its nature i.e. pain, stiffness, numbness etc.)

- ❑ neck __________
- ❑ upper back __________
- ❑ mid back __________
- ❑ low back __________
- ❑ shoulder __________
- ❑ arm __________
- ❑ wrist/hand __________
- ❑ hip __________
- ❑ knee __________
- ❑ ankle/foot __________
- ❑ other __________

RESPIRATORY

- ❑ chronic cough
- ❑ asthma / bronchitis
- ❑ pneumonia / emphysema
- ❑ sinus problems

ACCIDENT / INJURY

❑ Car Accident: ❑ Work Related ❑ Other

Date: __________

Symptoms: __________

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❑ Physical Limitations: __________

____

❑ ICBC / WCB Claim

SURGERY

Type: __________

Date: __________

HEAD

- ❑ tension headaches
- ❑ migraines
- ❑ tooth/jaw/ear pain
- ❑ clench/grind teeth
- ❑ dizziness/vertigo
- ❑ tinnitus
- ❑ hearing loss
- ❑ vision loss
- ❑ head trauma/date: __________

CARDIOVASCULAR

- ❑ high / low blood pressure
- ❑ heart attack
- ❑ phlebitis
- ❑ stroke/CVA
- ❑ pacemaker
- ❑ heart disease
- ❑ angina
- ❑ raynauds

INFECTIOUS DISEASE

- ❑ hepatitis
- ❑ infections skin conditions
- ❑ tuberculosis
- ❑ HIV
- ❑ other: __________

CURRENT MEDICATIONS / CONDITIONS:

❑ blood thinners ❑ steroids

____

____

Pins / Wires / Prosthetics : __________

____

SKIN

- ❑ skin condition/allergy: __________
- ❑ herpes
- ❑ athletes foot

OTHER CONDITIONS

- ❑ pregnant/due date: __________
- ❑ osteopenia/osteoporosis
- ❑ neurological condition: __________
- ❑ loss of sensation
- ❑ epilepsy
- ❑ diabetes/onset:
- ❑ allergies:
  - anaphylaxis: ❑ Yes ❑ No
- ❑ cancer
- ❑ arthritis:
  - type: ❑ OA ❑ RA
  - ❑ other: __________
  - where? __________
- ❑ constipation / diarrhea
- ❑ digestive problems
- ❑ insomnia
- ❑ haemophilia
- ❑ kidney / bladder problems
- ❑ menstrual issues
- ❑ other: __________

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OTHER TREATMENT RECEIVED?

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I have read the above information and have stated all my previous and current medical conditions. I take it upon myself to update my therapist regarding any changes in my condition. I understand that all treatments will be discussed and planned with my therapist, and will require my informed consent.
By my signature below, I authorise collection, use and disclosure of personal information, as defined in the Personal Information and Privacy Act (PIPA), required for treatment and any related administrative purpose. I understand that all my personal information is confidential, and must be treated in accordance with PIPA.

Signature: ______________________ Date: __________