HEALTH HISTORY FORM

How did you hear about our clinic?
Website ______Our sign______ Facebook______Other?_____________
Family/Friend/Co-Worker___ WHO?_______________________________
Permission to acknowledge the person who referred you________(Initials)

Name:_______________________________________ Date:_______________________
Address:_____________________________________ Telephone:(Home)_____________________
City:______________Prov:________ Postal Code:_____________ (Cell)________________________
(Work)____________________
Occupation:____________________________ Company:_______________________________
Email Address:__________________________________ Date of Birth(mm/dd/yy)____________________
Emergency Contact:______________________________ Telephone:____________________
Do you have Extended Health Care Insurance Coverage for Acupuncture/TCM? ☐ Yes ☐ No
Doctor's Name:_______________________________Telephone #:________________________
Permission to consult with your Doctor: ☐ Yes ☐ No Initials:________________________

Primary Complaint?________________________ Aggravates/Relieves?____________________
Have you seen a Doctor for this problem? ☐ Yes ☐ No When?___________________________
Overall, how is your general health?____

Please indicate conditions you are experiencing or have experienced:

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Emphysema
- ☐ Asthma
- ☐ Allergies
- ☐ Other_______________

Cardiovascular
- ☐ High/Low Blood Pressure
- ☐ Blood Clots
- ☐ Heart Disease/Heart Failure
- ☐ Myocardial Infarction
- ☐ Stroke/CVA
- ☐ **Pacemaker** or similar device
- ☐ Other_________________

Digestive
- ☐ Constipation/Diarrhea
- ☐ Gas/Bloating
- ☐ IBS
- ☐ Other______________

Nervous System
- ☐ Herpes/Shingles
- ☐ Numbness/Tingling
  Where?____________
- ☐ Chronic Pain
- ☐ Loss of Sensation
  Where?_____________
- ☐ Other_______________

Musculo-Skeletal
- ☐ Bone or Joint Disease
- ☐ Arthritis-Type______________
  Family Hx:_________________
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Sprains/Strains
- ☐ Low back/Hip/Leg pain
- ☐ Neck/Shoulder/Arm pain
- ☐ Jaw Pain/TMJ
- ☐ Other:_______________________

Reproductive
- ☐ Pregnant
- ☐ Due Date:________________
- ☐ Gynaecological:____________

Other
- ☐ Hepatitis
- ☐ Depression
- ☐ Diabetes-Type________
- ☐ Vision/Hearing Loss
- ☐ Headaches/Migraines
- ☐ Epilepsy
- ☐ Kidney Disease_______
- ☐ Other:______________

Infections:
- ☐ Allergies- ______________
- ☐ TB
- ☐ HIV/AIDS
- ☐ Other:________________
- ☐ Eczema/Psoriasis

Skin
- ☐ Bruise Easily
- ☐ Allergy to creams/lotions
- ☐ Athletes Foot
- ☐ Warts
- ☐ CFS/Fibromyalgia
- ☐ Other:__________________
- ☐ Cancer-_____________

Please turn over and complete other side⇒

Current Medications, Vitamins, Herbal Remedies & Conditions they treat:
Name:______________________________ Condition:____
Name:______________________________ Condition:____
Name:______________________________ Condition:____
Name:______________________________ Condition:____

Surgeries and Approximate Date:
Surgery:____ Date:_________________________
Surgery:____ Date:_________________________
Surgery:____ Date:_________________________

Motor Vehicle Accidents and Date
Accident & Injuries:____________________________________ Date:_________________________
Accident & Injuries:____________________________________ Date:_________________________

Other Accidents and Injuries:_____________________________ Date:_________________________
Presence of Internal Pins, Wires, Artificial Joints, Special Equipment, Etc.:___________________________

Other Therapies (Massage Therapy, Chiropractic, Physiotherapy etc.):_______________________________________

Do you have any other conditions not listed or is there anything about yourself you feel would be important for your Therapist to know:____

Consent Form:

It is important that you fill out this health history form to ensure that it is safe for you to receive treatment. If there are any changes to your health, please inform your therapist prior to your next session. All information gathered will be kept confidential except as required by law or to facilitate an assessment or treatment. Written authorization from you will be required before any information is released.

I agree to communicate with my therapist at any time if I have questions, if I feel uncomfortable, or if I feel my well-being is being compromised. I will give consent to my therapist to treat only on the areas of my body we discussed in the treatment plan. This may include sensitive areas such as gluteal/buttocks, breast/chest wall and upper inner thigh, if necessary. **Initials_________**

I am aware that I may remove only the clothing that I am comfortable removing. I know that I have the right to stop or modify the treatment at any time. It is my choice to receive the therapy. **Initials________**

Cancellation Policy: You will be charged the full cost of the treatment as booked, if you do not show up for your scheduled appointment, and you have not notified us at least 24 hours in advance (not illness related). Our late cancellation fee will be waived if you cancel due to illness or suspected illness. We would prefer to reschedule your appointment if you are ill. Please try to give us appropriate notice.

Signature:____ Date:_________________________
Parent/Guardian Signature:________________________________ Date:_________________________
(if under 16 years of age)

Permission Form:
I, _____________________________________ give permission for the clinic of **Chippawa Therapeutics** to send informational material via mail or email. Personal Information collected by the clinic will not be used for any other purposes. ☐ Yes ☐ No
My email address is:____
Signature:____Date:_________________________________

For office use only:
History:_____________________
Update 1:____________________ Update 2:________________________Update 3:_________________________