OSTEOPATHY

Confidential Patient History

Please complete the following mandatory questionnaire. Your answers will help us determine the best approach for your kinesiology care. Thank you!

Full Name: _____ DOB: _____

Health Information

Reason for attending office:_____
Location of pain:_____
When did you notice it? _____ How often does it occur? _____
Does it radiate? ☐ Yes ☐ No If yes where? _____
What relieves it? _____
What aggravates it? _____
When have you had this or similar conditions in the past? _____
Is condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes
Other treatments tried? _____

Past Health Information

Please check if you presently have or have had any of the following conditions in the past:

☐ Blurring of vision	☐ Bronchitis	☐ Diarrhea	☐ Insomnia
☐ Stroke	☐ Asthma	☐ Stomach Ulcer	☐ Respiratory Condition
☐ Dizziness	☐ Tendonitis	☐ Heart Burn	☐ Urinary Frequency
☐ Depression	☐ Chest Pains	☐ Headaches	☐ Lower Back Pain
☐ Heart Disease	☐ Diabetes	☐ Allergies	☐ High Blood Pressure
☐ Aneurysm	☐ Hiatus Hernia	☐ Sinusitis	☐ Menstrual Problems
☐ Varicose Veins	☐ Constipation	☐ Ringing in ears	☐ Numbness or Tingling in arms or legs
☐ Cancer	☐ Arthritis	☐ Osteoporosis	

Other health problems:
_____
_____

List surgical operations or hospitalizations and years they occurred:

_____

_____

Pregnancies:_____

List of medications or vitamins you now take:

_____

_____

List and describe any auto accidents or other accidents/injuries:

_____

_____

List and describe any childhood injuries/accidents/hospitalizations/illnesses:

_____

_____

Anything else you feel we should know about?

_____

_____

Show area(s) of pain or unusual feeling.

Mark the areas on this body where you feel the described sensations.

Use appropriate symbols.

Mark areas of radiation.

Include all affected areas.

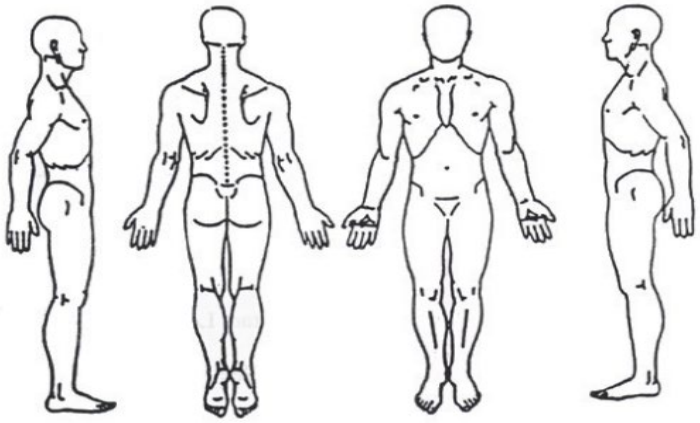
Numbness
● ●
● ●
● ●

Pins & Needles
○ ○
○ ○
○ ○

Burning
X X
X X
X X

Aching
* *
* *
* *

Stabbing
/ /
/ /
/ /



Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours' notice of cancellation, or a cancellation fee will be charged. Payment for all treatments, whether private or insured, is ultimately the responsibility of the patients. Late cancelation fees will be 50% of scheduled appointment time. Under one-hour notice OR no show will be charged the full appointment fee

I authorize the clinic and its associated health care professionals to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated health care professionals to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Full Name: _____

Signature: _____ **Date: _____**