



Better Health Clinic

Osteopathy Health History Form

Name:

Date:

Address:

DOB:

Phone (H)

(W)

(C)

Email:

Emergency Contact:

Emergency Phone No:

Occupation:

Employer:

Family Doctor:

How did you hear about us?

Presenting Complaints primary/secondary:

Type of Symptoms (circle): Achiness, Sharp, Dull, Deep, Superficial, Vague, Local, Numbness, Tingling, Referring

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Onset:

Front Back

Pain XXXXXX
 Achiness ////
 Numbness oooooo
 pins and needles

Previous episodes:

Progression:

Aggravating Factors:

Relieving Factors:





Better Health Clinic

Previous Treatment for this Complaint: Medical Doctor____ Massage Therapist____ Chiropractor____
Osteopath____ Other Health Care Professional_____

Lifestyle factors smoking/alcohol/recreation over what period and how much:

Medications current/previous:

Hospitalisations including births, surgeries, fractures, dislocations and illnesses:

Motor Vehicle Accidents and Other Trauma (falls, sports injuries):

List any imaging (X-Ray, MRI, CT, Ultrasound, Bone density) taken recently or previously and their results:

Please mark conditions that apply to you. Mark a "C" for a Current condition and "P" for a Previous condition.

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Diarrhoea	<input type="checkbox"/> Asthma
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Food sensitivity	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Chills	<input type="checkbox"/> Gall bladder issues	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Depression	<input type="checkbox"/> Heart burn	<input type="checkbox"/> Wheezing/coughing
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Fainting	<input type="checkbox"/> Nausea	<input type="checkbox"/> Painful urination
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Urinary infection
<input type="checkbox"/> Headaches	<input type="checkbox"/> Ear aches	<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Migraines	<input type="checkbox"/> Tinnitus/ringing in ears	<input type="checkbox"/> Prostate disease
<input type="checkbox"/> Unexplained loss of weight	<input type="checkbox"/> Deafness	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Tremors	<input type="checkbox"/> Sinus Infections	<input type="checkbox"/> Menopausal
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Gynaecological condition
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Cramps with menstruation
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Hernia	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Infectious skin condition	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Inability to control bladder
<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthrosclerosis	<input type="checkbox"/> Cancer
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Heart attack	<input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Colitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Constipation	<input type="checkbox"/> Blood pressure high/low	Other
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	