Sheryl Crotta BA, M.OMSc. - Osteopathic Manual Therapist
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Please complete this Health History form as accurately as possible help to ensure that you receive safe and effective treatment. If at any time your health status changes, please let me know as soon as possible prior to your treatment. All information is strictly confidential. Please note: It is not the policy of this clinic to provide copies of clinical notes /documents to organizations or individuals.

Name: _____

Address: _____

City: _____Postal Code: _____

Phone (H)_____(W)_____Cell _____

Email : _____

Age_____ Date of Birth: _____Ht:_____Wt:_____

Occupation: _____

Family Physician: _____Phone_____

Physician's Address:_____

Reason for Treatment: _____

How/Where did you hear about this clinic?_____

Head and Neck
____ Headache
____ TMJ dysfunction
____ Thyroid
____Dizziness/Vertigo
____Earaches
____Sinus
____Oral/Nasal Secretions

Muscle & Joint
____Pain
____Stiffness
____Swelling
____Limited Motion
____Fatigue
____Osteoarthritis
____Rheumatoid Arthritis
____Back Pain
Upper___Mid___Lwr___
____Upper Limb Pain
____Lower Limb Pain

Urogenital (Male/Female)
Fertility_____
Reproductive _____
Menstruation
___Painful
___Heavy
___Light
___Normal
___Irregular
___Absent
___Pregnant
___Children#____
___Menopause
___Hysterectomy

Respiratory
____Chronic Cough
____Shortness of Breath
____Asthma
____Bronchitis
____Emphysema

Skin
____Sensitive Skin
____Rashes/Acne
____Numbness
____Moles/Spots
____Eczema/Psoriasis
____Varicose Veins
____Deep Vein Thrombosis
____Recent Tattoos
____Recent Piercing
____Recent Surgery

Cardiovascular
____High/Low Blood Pressure
____High/Low Cholesterol
____Poor Circulation
____Heart Surgery
____Heart Disease
____Pacemaker
____Stroke
____Arrhythmia

Digestive
____Poor Digestion
____IBS/IBD/Crohn's
____Diarrhea/Constipation
____Blood/Mucus in stool
____Bloating/Discomfort
____Liver/Gallbladder
____Kidney/Bladder
____Gas

HEENT (eyes,ears…)
____Vision Problem
____Hearing Loss
____Nausea/vomiting
____Swallowing difficulty
____Ear (infection/tubes)

General Health Status
____Good
____Average
____Poor

General Stress Level
____High
____Moderate
____Low

Dietary Habits
____Regular Meals
____Irregular Meals
____Caffeine
____Smoke
Pkg(s)/day_____

Physical Activity
____Regular
____Occasional
____None

Sleep Quality
____Poor/Good Quality

Previous Health Care
____Osteopathy
____Chiropractic
____Physiotherapy
____Acupuncture
____Naturopathy
____Massage Therapy

Conditions
Cancer _____
Diabetes_____

Date of last full physical
_____

Infectious Condition(s)____ ____HIV ___TB ___Hepatitis ____Open wound

Allergies:_____
Recent Surgery/Wound: _____

Current prescription medications & non-prescription medications and reason for use:

_____
_____

Date of accident or surgery:

_____

Date of accident or surgery:

_____

Date of accident or surgery:

_____

Date of accident or surgery:

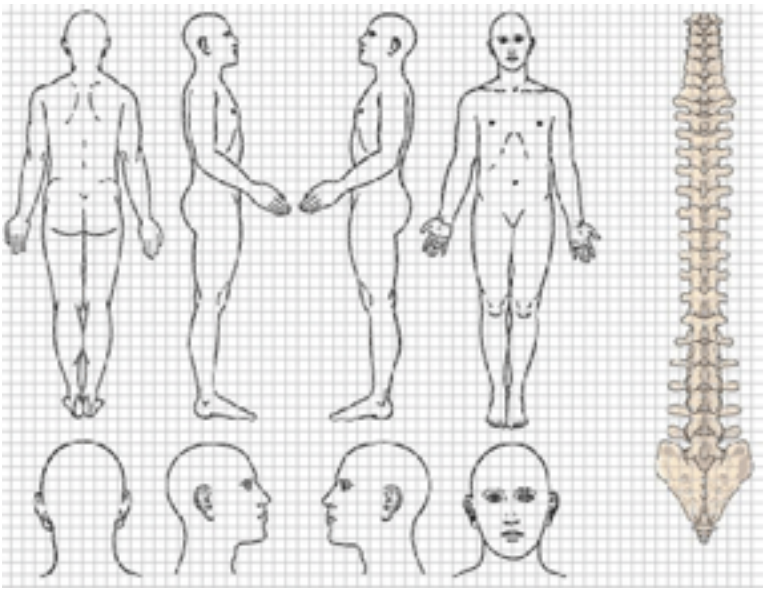
_____

Dental surgery/procedures:

_____

Orthopaedic Appliances/Surgical Implants: Pins, Wires, Prosthetics, Walker, Cane, Oral Appliances, Pacemaker, Orthotics, Pacemaker, Cosmetic surgeries etc.

_____
_____



Using these diagrams circle any areas of discomfort and any details:

Please use this area for any additional information or details_____
_____
_____
_____
_____

Client Agreement

This form has been outlined so that you fully understand the office policies pertaining to this clinic. It is advisable that you fully read this form.
If you have any questions, please ask prior to signing. Thank you.

1. All information recorded on the health history form is essential to providing you the most effective and safe treatment possible. In signing this form you understand that everything discussed and/or recorded is **strictly confidential.**

2. As a Patient/Client, it is necessary to have a full assessment performed this is required for so that a relevant, safe, effective treatment plan can be set up for you. New health history forms must be revised after a long duration away from treatment, when seeing a new therapist for the first time or if your health status changes dramatically. The assessment is part of the initial treatment and will take a portion of the session. Periodically, a new health history form may be requested to be completed to ensure all information is current.

3. Payment can be made in **CASH or CHEQUE or** and a receipt will be issued to you following treatment, cheques returned **(NSF) will be subject to a service fee of $40.**

4. **Fees:** Please see website for full details

5.**Missed appointments without 24 hours notice** will be issued a **$60 cancellation fee** for the missed scheduled appointment **except** in the event of emergency or illness.

6. Please arrive 5 minutes prior to your scheduled appointment time if possible.
In case of **late arrivals,** it is fully understood that **only the time remaining for your scheduled treatment will be available**.

7. **It is not my policy to work through WSIB claims or MVA (motor vehicle accidents) claims**; In the event you do require a therapist that does work with these types of claims, I will attempt to suggest a local therapist for you.

8. **It is not my policy to provide copies of file notes and/or documents to any individual or organization.**

9. Patients under the age of 12 **must** have a parent or legal guardian accompany for the initial assessment and follow up visits and **must** co-sign this agreement.

Print Name: _____

Date & Signature: _____
Signature of parent or guardian (if required):

Date & Signature _____