



## Client Health History Form (cont.)

<p><b>Cardiovascular System</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> aneurysm</li> <li><input type="checkbox"/> high blood pressure/hypertension</li> <li><input type="checkbox"/> low blood pressure/hypotension</li> <li><input type="checkbox"/> heart disease</li> <li><input type="checkbox"/> stroke</li> <li><input type="checkbox"/> varicose veins</li> <li><input type="checkbox"/> phlebitis</li> <li><input type="checkbox"/> bruise easily</li> <li><input type="checkbox"/> pacemaker</li> </ul>	<p><b>Nervous System</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> multiple sclerosis</li> <li><input type="checkbox"/> Parkinson's</li> <li><input type="checkbox"/> seizures/epilepsy</li> <li><input type="checkbox"/> carpal tunnel</li> <li><input type="checkbox"/> altered/loss of sensation</li> </ul> <p>Specify areas:</p> <p>_____</p> <p>_____</p>	<p><b>Medications</b></p> <p>Please indicate type, what it is for and the times that it is taken:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Digestive Systems</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> ulcers</li> <li><input type="checkbox"/> constipation</li> <li><input type="checkbox"/> ulcerative colitis</li> <li><input type="checkbox"/> Crohn's disease</li> <li><input type="checkbox"/> gall stones</li> <li><input type="checkbox"/> irritable bowel syndrome (IBS)</li> <li><input type="checkbox"/> liver disease</li> </ul> <p>Other (specify):</p> <p>_____</p>	<p><b>Skin</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> plantar warts</li> <li><input type="checkbox"/> eczema</li> <li><input type="checkbox"/> psoriasis</li> <li><input type="checkbox"/> fungal infection (ex. athlete's foot)</li> <li><input type="checkbox"/> herpes simplex</li> </ul> <p>Other (specify):</p> <p>_____</p> <p>_____</p>	<p><b>Respiratory Systems</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> bronchitis</li> <li><input type="checkbox"/> asthma</li> <li><input type="checkbox"/> emphysema</li> <li><input type="checkbox"/> sinusitis</li> <li><input type="checkbox"/> chronic cough</li> <li><input type="checkbox"/> breathing problems</li> </ul> <p>Specify:</p> <p>_____</p> <p>_____</p>
<p><b>Head/Neck</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> history of headaches</li> <li><input type="checkbox"/> history of migraines</li> <li><input type="checkbox"/> vision problems or loss</li> <li><input type="checkbox"/> hearing/ear problems</li> <li><input type="checkbox"/> dizziness</li> </ul>	<p><b>Other Conditions</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> hepatitis</li> <li><input type="checkbox"/> HIV/AIDS</li> <li><input type="checkbox"/> diabetes</li> <li><input type="checkbox"/> chronic fatigue syndrome</li> <li><input type="checkbox"/> environmental illness</li> <li><input type="checkbox"/> allergies</li> </ul> <p>Specify:</p> <p>_____</p> <p>_____</p>	<p><b>Muscles and Joints</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> fibromyalgia</li> <li><input type="checkbox"/> osteoporosis</li> <li><input type="checkbox"/> arthritis</li> </ul> <p>Specify type and location:</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> pain/stiffness:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> head</li> <li><input type="checkbox"/> neck</li> <li><input type="checkbox"/> jaw</li> <li><input type="checkbox"/> back                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Lower</li> <li><input type="checkbox"/> Middle</li> <li><input type="checkbox"/> Upper</li> </ul> </li> <li><input type="checkbox"/> arm/hand</li> <li><input type="checkbox"/> leg/foot</li> </ul>
<p><b>Women</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> menopausal problems</li> <li><input type="checkbox"/> painful menstruation</li> <li><input type="checkbox"/> pregnant</li> </ul> <p>Due date:</p> <p>_____</p> <p><input type="checkbox"/> caesarean section</p> <p><input type="checkbox"/> endometriosis</p> <p>Other (specify):</p> <p>_____</p> <p>_____</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> tumours/cysts</li> <li><input type="checkbox"/> cancer</li> </ul> <p>Specify:</p> <p>_____</p> <p>_____</p> <p>Other (specify):</p> <p>_____</p> <p>_____</p>	
<p><b>Other Healthcare</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> physician/medical doctor</li> <li><input type="checkbox"/> chiropractor</li> <li><input type="checkbox"/> massage therapist</li> <li><input type="checkbox"/> physiotherapist</li> <li><input type="checkbox"/> naturopathic doctor</li> <li><input type="checkbox"/> nutritionist/dietician</li> </ul> <p>Other (specify):</p> <p>_____</p> <p>_____</p>	<p><b>Surgeries</b></p> <p>Please indicate type, area(s) and date of surgery:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Previous Injuries</b></p> <p>Please indicate area(s), date of injury and a brief description of what happened:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

By my signature below, I authorize that all of the information is filled to the best of my knowledge. I understand that all my personal information is confidential and will be treated in accordance with the Personal Information Act.

**Please allow 24 hours notice for cancellation of appointments. There will be a fee for any appointments missed without sufficient notice. Cannot be billed through insurance company for fee coverage.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_