KEYSTONE HEALTH

5 - 34 Harvard Rd Guelph, Ontario N1G 4V8 226-326-3232 **mykeystonehealth.ca**

Name

Address, city, province, postal code

Date of birth (YYYY/MM/DD)

Occupation

Home phone #

Work #

Cell #

Email

How did you hear about our clinic?

All information provided is private (PIPEDA compliant). Your therapist and their support staff are the only ones who have access to your health history information. No access to your file will be granted to anyone outside our clinic without your written permission. The above information will be used to contact you if an appointment needs to be moved, for confirmation, or to inform you if there are important changes to our clinic. Please do not hesitate to ask your therapist about our privacy policies.

Have you ever had Osteopathic Manipulative Therapy before? Yes ◯ No ◯ Not sure ◯

Please check off any conditions that apply (**P** = Previous, **C** = Current):

	P	C
General		
Fatigue	◯	◯
Allergies	◯	◯
Loss of sleep	◯	◯
Fever	◯	◯
Headaches	◯	◯
CVR		
Chest pain	◯	◯
Short breath	◯	◯
Blood pressure problems	◯	◯
Irregular heartbeat	◯	◯
Heart problems	◯	◯
Lung problems/ congestion	◯	◯
Genito-Urinary		
Bladder problems	◯	◯
Painful/excessive urine	◯	◯
Discoloured urine	◯	◯
Eyes/Ears/Nose/Throat		
Vision problems	◯	◯
Dental problems	◯	◯
Sore throat	◯	◯
Ear aches	◯	◯
Hearing difficulty	◯	◯
Sinus problems	◯	◯
Other Conditions		
Diabetes	◯	◯
Epilepsy	◯	◯
Cancer	◯	◯
Arthritis	◯	◯

	P	C
Male/Female		
Menstrual irregularities	◯	◯
Menstrual cramping	◯	◯
Vaginal pain/infection	◯	◯
Breast pain/lumps	◯	◯
Prostate dysfunction	◯	◯
Sexual dysfunction	◯	◯
Gastro-Intestinal		
Poor/excessive appetite	◯	◯
Excessive thirst	◯	◯
Frequent nausea	◯	◯
Vomiting	◯	◯
Diarrhea	◯	◯
Constipation	◯	◯
Hemorrhoids	◯	◯
Liver problems	◯	◯
Gall bladder problems	◯	◯
Weight problems	◯	◯
Abnormal cramps	◯	◯
Gas/bloating after meals	◯	◯
Heartburn	◯	◯
Black/bloody stool	◯	◯
Colitis	◯	◯
Infections		
Hepatitis	◯	◯
Skin conditions	◯	◯
TB	◯	◯
HIV	◯	◯

	P	C
Musculo-Skeletal		
Low back pain	◯	◯
Pain between shoulders	◯	◯
Neck pain	◯	◯
Arm pain	◯	◯
Joint pain/stiffness	◯	◯
Walking problems	◯	◯
Jaw problems	◯	◯
General stiffness	◯	◯
Nervous System		
Nervous	◯	◯
Numbness	◯	◯
Paralysis	◯	◯
Dizziness	◯	◯
Forgetfulness	◯	◯
Confusion/depression	◯	◯
Fainting	◯	◯
Convulsions	◯	◯
Cold/tingling extremities	◯	◯
Stress	◯	◯

Please check as many that apply:

Are you pregnant? Yes ◯ No ◯

If yes, when are you due (YYYY/MM/DD)?

Regular exercise program? Yes ◯ No ◯

How would you rate your lifestyle stress levels?

Low ◯ Moderate ◯ High ◯

Do you feel discomfort?

On the chart, please circle any areas where you feel discomfort or any radiation of pain.

I have filled out the health history form to the best of my knowledge and give consent to receive treatment today.

Date

Signature

Guardian signature (if under 14 years old)