



KEYSTONE HEALTH

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

Name

Home phone #

Address, city, province, postal code

Work #

Cell #

Date of birth (YYYY/MM/DD)

Email

Occupation

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.

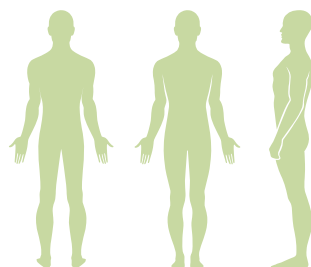
Have you ever had Osteopathic Manipulative Therapy before? Yes No Not sure

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

	P	C		P	C		P	C
General			Male/Female			Musculo-Skeletal		
Fatigue	<input type="radio"/>	<input type="radio"/>	Menstrual irregularities	<input type="radio"/>	<input type="radio"/>	Low back pain	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>	Menstrual cramping	<input type="radio"/>	<input type="radio"/>	Pain between shoulders	<input type="radio"/>	<input type="radio"/>
Loss of sleep	<input type="radio"/>	<input type="radio"/>	Vaginal pain/infection	<input type="radio"/>	<input type="radio"/>	Neck pain	<input type="radio"/>	<input type="radio"/>
Fever	<input type="radio"/>	<input type="radio"/>	Breast pain/lumps	<input type="radio"/>	<input type="radio"/>	Arm pain	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	Prostate dysfunction	<input type="radio"/>	<input type="radio"/>	Joint pain/stiffness	<input type="radio"/>	<input type="radio"/>
CVR			Gastro-Intestinal			Nervous System		
Chest pain	<input type="radio"/>	<input type="radio"/>	Poor/excessive appetite	<input type="radio"/>	<input type="radio"/>	Nervous	<input type="radio"/>	<input type="radio"/>
Short breath	<input type="radio"/>	<input type="radio"/>	Excessive thirst	<input type="radio"/>	<input type="radio"/>	Numbness	<input type="radio"/>	<input type="radio"/>
Blood pressure problems	<input type="radio"/>	<input type="radio"/>	Frequent nausea	<input type="radio"/>	<input type="radio"/>	Paralysis	<input type="radio"/>	<input type="radio"/>
Irregular heartbeat	<input type="radio"/>	<input type="radio"/>	Vomiting	<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>
Heart problems	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>	Forgetfulness	<input type="radio"/>	<input type="radio"/>
Lung problems/ congestion	<input type="radio"/>	<input type="radio"/>	Constipation	<input type="radio"/>	<input type="radio"/>	Confusion/depression	<input type="radio"/>	<input type="radio"/>
Genito-Urinary			Infections			Please check as many that apply:		
Bladder problems	<input type="radio"/>	<input type="radio"/>	Hemorrhoids	<input type="radio"/>	<input type="radio"/>	Are you pregnant? Yes <input type="radio"/> No <input type="radio"/>		
Painful/excessive urine	<input type="radio"/>	<input type="radio"/>	Liver problems	<input type="radio"/>	<input type="radio"/>	If yes, when are you due (YYYY/MM/DD)?		
Discoloured urine	<input type="radio"/>	<input type="radio"/>	Gall bladder problems	<input type="radio"/>	<input type="radio"/>	Regular exercise program? Yes <input type="radio"/> No <input type="radio"/>		
Eyes/Ears/Nose/Throat						How would you rate your lifestyle stress levels?		
Vision problems	<input type="radio"/>	<input type="radio"/>	Weight problems	<input type="radio"/>	<input type="radio"/>	Low <input type="radio"/> Moderate <input type="radio"/> High <input type="radio"/>		
Dental problems	<input type="radio"/>	<input type="radio"/>	Abnormal cramps	<input type="radio"/>	<input type="radio"/>	I have filled out the health history form to the best of my knowledge and give consent to receive treatment today.		
Sore throat	<input type="radio"/>	<input type="radio"/>	Gas/bloating after meals	<input type="radio"/>	<input type="radio"/>	Date		
Ear aches	<input type="radio"/>	<input type="radio"/>	Heartburn	<input type="radio"/>	<input type="radio"/>	Signature		
Hearing difficulty	<input type="radio"/>	<input type="radio"/>	Black/bloody stool	<input type="radio"/>	<input type="radio"/>	Guardian signature (if under 14 years old)		
Sinus problems	<input type="radio"/>	<input type="radio"/>	Colitis	<input type="radio"/>	<input type="radio"/>			
Other Conditions								
Diabetes	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>			
Epilepsy	<input type="radio"/>	<input type="radio"/>	Skin conditions	<input type="radio"/>	<input type="radio"/>			
Cancer	<input type="radio"/>	<input type="radio"/>	TB	<input type="radio"/>	<input type="radio"/>			
Arthritis	<input type="radio"/>	<input type="radio"/>	HIV	<input type="radio"/>	<input type="radio"/>			

Do you feel discomfort?

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



Date

Signature

Guardian signature (if under 14 years old)