acacia INTEGRATIVE HEALTH CLINIC *Creating health together, through science and nature.*

Athletic Therapy/ Osteopathic Manual Practice Health History Form

Name_____ Birth-date _____ Date_____ MSP #_____

Blood Type_____ Address_____ City _____ Prov/State_____

Postal Code_____ Phone (home)_____ Phone (work) _____

best time to call _____ Can we leave messages for you here? Y ☐ N ☐ Email _____

Occupation_____ full-time☐ part-time☐

Emergency contact _____relation? _____Phone_____

How did you hear about us?_____

Please list below all other health professionals you are currently seeing (complimentary and conventional) and their contact numbers. Include their area of practice (GP, ND, etc...)_____

_____

_____

Current Health Concerns:

What is your main reason for seeking athletic therapy and osteopathic manual techniques?

_____

_____

_____

_____

_____

_____

_____

How long has this been troubling you? _____Has it been getting: better ☐ worse ☐ remaining the same ☐
List any treatments you have had for this condition (surgery, acupuncture, massage, etc...) *and the results*. Include dates: _____

_____

_____

Your Lifestyle:

What do you enjoy most in your life? _____

What are your main interests and hobbies? _____

How often do you exercise per week? _____ What kind and for how long? _____

Acacia Integrative Health Clinic
Suite #101-391 Tyee Rd Dockside Green, Victoria, B.C., V8W 2J9
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Your Health History:

Your general state of health is: excellent ☐ good ☐ average ☐ fair ☐ poor ☐

Current weight_____ Height _____ Weight 1 year ago _____Max adult weight _____ Min adult weight _____

Childhood Diseases: (please circle if you have had the following):

measles	mumps	chickenpox	whooping cough	polio	diphtheria	roseola
rheumatic fever	scarlet fever	small pox	typhoid fever	tuberculosis	rubella	mono

Current Medications, Herbs, Suppliments:

_____

_____

Which of the following have you had and indicate when.

Chronic infections_____	Hypoglycemia_____	Asthma_____	Heart attack_____
Pneumonia_____	Diabetes_____	Gonorrhea_____	Heart Failure_____
Tonsillitis_____	Cancer_____	Syphilis_____	Anemia_____
Ear Infections_____	Eczema_____	Venereal warts_____	Obesity_____
Heart disease_____	Epilepsy_____	Canker sores_____	Hyperthyroidism_____
Oral herpes_____	Genital herpes_____	Hypertension_____	Hypothyroidism_____
Allergies_____	Hepatitis_____		

How often do you get colds and flus? _____

Do you have any allergies to any drugs, herbs, foods, animals or other? (yes / no) Please list:

_____

_____

Do you currently use any of the following (indicate how often, how much and for how long):

Alcohol_____	Tobacco_____	Coffee _____
Soft drinks_____	Black tea _____	Marijuana _____
Laxatives _____	Other recreational drugs _____	Pain medication _ _____
Other intoxicants_____		

Injury History:

Please list all health concerns, injuries and/or surgeries:

Concussion_____	Neck Injury_____	Splenic_____	Upper Extremity_____
Head Injury_____	Mid-spine injury_____	Lymphatic_____	Hip_____
Ear Infections_____	Lower back injury_____	Hepatic_____	Knees_____
Throat Infections_____	Pelvic Injury_____	Renal_____	___Ankle_____
Vision Issues_____	Respiratory _____	Digestive_____	____ Foot_____
Facial Injury_____	Cardiac Issues_____	Reproductive _____	Endocrine Issues_____
Major Dental Work_____	Pancreatic_____		

Other:_____

_____

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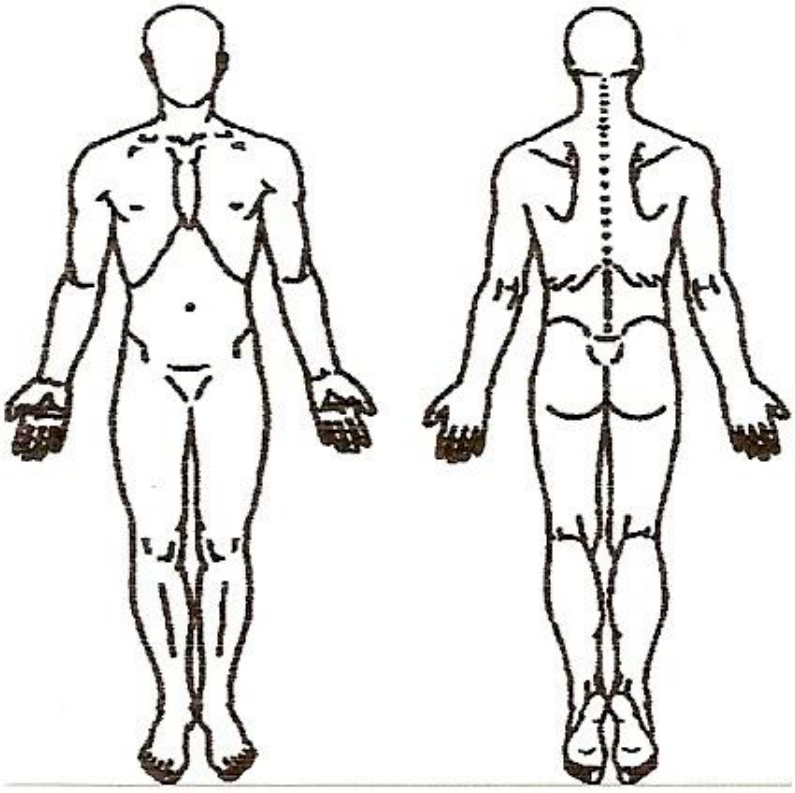
Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching	O O
Stabbing	X X X
Shooting	→ →
Burning	# # #
Numbness or Tingling	≈ ≈

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Confidentiality Agreement and Informed Consent to Treatment

Osteopathy is a natural medicine and science based on a holistic approach that treats the entire person. The principles of osteopathy are based upon the relationship between structure and function and a deep understanding of the connection between all tissues, fluids and systems in the body. Osteopathic Manual Practitioners use orthopaedic manual tests to find the cause of the problem, then employ gentle, hands-on techniques aimed at resolving the issue at its source.

Osteopathic treatments can reduce muscle, tendon, ligament and joint pain and dysfunction - with many additional benefits such as improved posture and joint mobility, circulation, and neural function. These improvements in turn can benefit other body systems such as enhanced digestion and elimination.

I understand that I must inform the Athletic Therapist / Osteopathic Manual Practitioner (student) immediately of any disease process that I may be suffering from, if I am on any medication or over the counter drugs, if I am pregnant, suspect I may be pregnant or am breast-feeding.

I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that the physicians at this clinic are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats to harm or kill another individual and serious threat of suicide involved with my case. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory tests.

I understand that 24 hours notice is required for appointment cancellation; otherwise I will be responsible for the cancellation fee.

I understand that the results are not guaranteed. I do not expect the Athletic Therapist / Osteopathic Manual Practitioner (student) will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of treatment with this Athletic Therapist / Osteopathic Manual Practitioner (student). I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient/Guardian Name: (Please Print) _____

Signature of Patient (or Guardian): _____

Date: _____

*Optional Consent (please **initial** box)*

☐ To provide me with truly integrated medical care I hereby give my consent to share my file and/or my medical history and current treatment plan options with any other practitioner that I am currently seeing (or may be referred to see in the future) at Acacia Integrative Health Clinic for the sole purpose of improving my current health condition and/or to discuss current and/or future treatment options.

Athletic Therapist / Osteopathic Manual Practitioner (student) Signature: _____

Date: _____

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