



Athletic Therapist/ Osteopathic Manual Practice Health History Form

Name _____
Birthdate _____ Today's Date _____

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? _____

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**Athletic Therapy/
Osteopathic Manual Practice
Health History Form**

Your Health History:

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

Current weight _____ Height _____ Weight 1 year ago _____

Childhood Conditions/Syndromes: (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, Supplements:

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 _____		

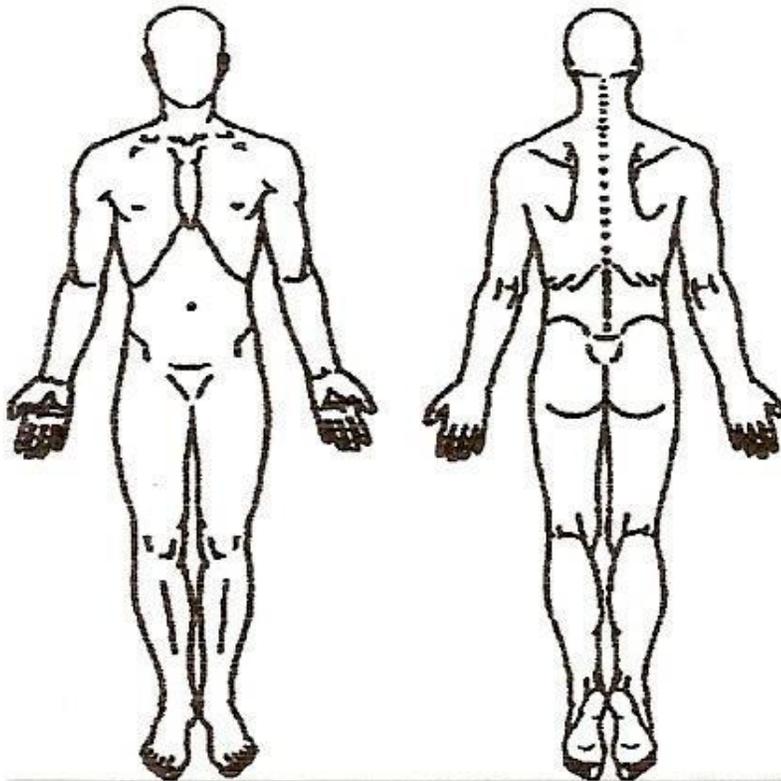
Injury History:

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: _____

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



- | | |
|-------------------------|-------|
| Aching | ○ ○ |
| Stabbing | X X X |
| Shooting | → → |
| Burning | # # # |
| Numbness
or Tingling | ≈ ≈ |
| Loss of
Sensation | ▲ ▲ |



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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 orthopedic 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: _____