Achieve Balance
Holistic Health

Health History Form

DATE _____

NAME_____

ADDRESS _____

EMAIL_____

TEL HOME _____ BUSINESS_____ MOBILE_____

OCCUPATION _____

EMPLOYER_____

Referred by_____

Date of Birth_____

Physician's Name_____ Phone #_____

Emergency Contact:

Name _____ Phone # _____

Primary complaint/reason for treatment: _____

_____

_____

Pain location: _____

Intensity of pain on a scale of 1-10 _____

Have you received any other form of bodywork in the past five days? Please indicate type.

_____

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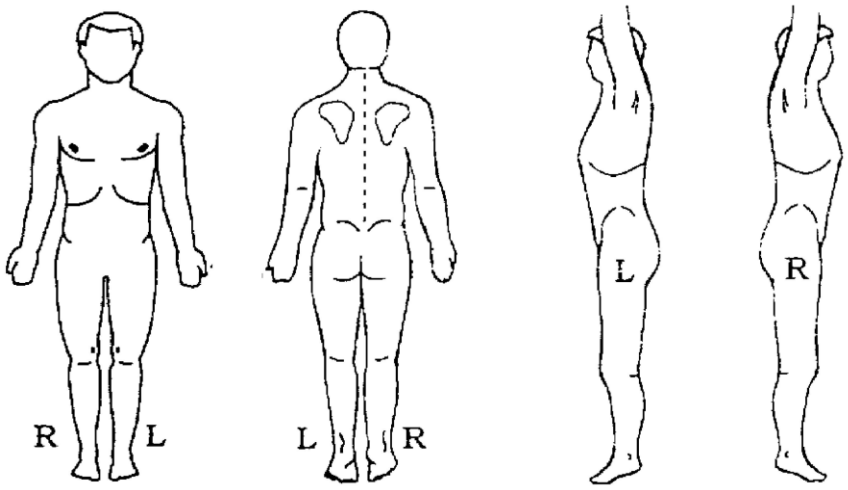
Pain patterns/restricted movements:



What medications are you currently taking?

_____

_____

List surgeries with dates: (Please include TMJ or oral surgery)

_____

_____

_____

List hospitalizations with dates:

_____

_____

_____

List previous injuries with dates:

_____

_____

_____

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Are you pregnant or trying to conceive? _____

Pregnant: Due date: _____

Last menstrual period: _____

Indicate your own birth history (if known): i.e., C-section, forceps, breach birth, premature

_____

Do you have any metal implants, internal pins, wires, artificial joints or special equipment?

_____

Do you wear orthotics? _____ How long for current pair _____

Do you smoke? _____ How much? _____ How long? _____

What is your daily consumption of water _____ Tea _____ Coffee_____

Soft drinks _____ Alcoholic beverages _____

Please indicate conditions you are experiencing or have a history of with explanation:

- Asthma/Bronchitis/shortness of breath or chronic cough_____
- Poor circulation/bruise easily _____
- PMS, fibroids/difficult menstruation_____
- Liver/gallbladder/poor digestion_____
- Insomnia _____
- Hiatus hernia _____
- Constipation/diarrhea - please indicate number of BMs per day or per week

_____

- Numbness/tingling/loss of sensation in hands or feet _____

- Diabetes - Date of Onset: _____
- Allergies (Anaphylaxis/skin irritation/food allergy)_____
- Hay fever _____
- Epilepsy _____
- Cancer_____
- Arthritis_____
- Vision problems_____
- Ear infections/poor hearing/tinnitus_____
- Bladder/kidney_____
- Joint or soft tissue pain_____
- High or low blood pressure_____
- Heart attack_____
- Congestive heart failure, heart disease, stroke_____
- Phlebitis _____
- Pacemaker_____
- Headaches (frequency and triggers)_____
- Hepatitis, TB _____
- Skin rashes/infectious skin conditions_____
- Fibromyalgia_____
- Mononucleosis_____
- Back pain_____

- Varicose veins_____
- Psychological issues i.e., depression, anxiety, etc. _____
- Is there any other condition or issue not previously mentioned, physical or emotional that you have experienced in your lifetime?

_____

_____

_____

I, (print)_____
understand the treatment goals, risks and benefits as explained by the practitioner and I give consent to treatment. I have had an opportunity to ask questions about the treatment. I understand that Andrée Boisvert does not treat, prescribe or diagnose any illness, disease, or other physical or mental disorder and that any information concerning health status relayed to the practitioner has also been given to my physician. I also certify that no guarantee has been made as to the results that may be obtained.

I hereby give Andrée Boisvert permission to collect personal information on a strictly confidential basis, including personal health information from me. This information may not be released to any other individual or health care provider without my prior written consent. Health care providers may include my health care team i.e., physician, pharmacist, naturopath, RMT, chiropractor or other regulated health care provider. I understand I may request access to my personal information and may revoke or amend this authorization in writing at any time.

Signature_____ Date _____

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