HYDROSTONE OSTEOPATHY

HEALTH HISTORY

Patient Name : _____

Address: _____
_____
_____

Telephone (home) _____
(work) _____
(cell) _____

Email: _____

Date of Birth: _____

How did you hear about this clinic/therapist:
_____

Referral Source: _____

Family Doctor: _____

Health and Occupational History

Occupation: _____
Hobbies: _____

Medications: _____
_____

Previous Surgery: _____
_____

Please list any health conditions you presently have: _____
_____
_____
_____

Have you had (please circle): X-rays? Blood tests?

Treatment-related Information

Diagnosis (if applicable): _____

Previous treatment for this condition: _____
_____
_____

Please briefly describe your symptoms: _____
_____
_____
_____

It is important that your choices regarding massage therapy sessions be informed and voluntary. You have the right to ask me to modify any part of the treatment, or to stop the treatment at any time. It is necessary that I have your feedback and input in order to give you the most benefit from treatment. All records are confidential unless otherwise requested with your authorization.

If you would like me to forward a copy of your treatment summary to your family doctor or referring health care practitioner please sign here: ……

I have read and understood the all of the above.

Signature:……