ellephysio Health History Form

Name ______________________________	Today's Date _______________________
Address ____________________________	Date of Birth _______________________
____________________________	Telephone Home: (_) ____________
Email ______________________________	Cell: ( ) ____________
Occupation __________________________	Work: (_) ____________
Family Physician ______________________	Emergency Contact Name: _______________
Physician Telephone ( ) ____________	Telephone: ( ) __________

Are you seeking treatment as a result of a work-related injury? ☐ YES ☐ NO

Are you seeking treatment as a result of a motor vehicle accident? ☐ YES ☐ NO

How did you hear about ellephysio? ☐ Doctor Referral ☐ Mid-wife Referral ☐ Facebook ☐ Twitter

☐ You are a Previous Client ☐ Another Client Recommended / Name: ______________________

What are your reasons for attending this clinic? ____

What is your current Health Status? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Please list any limitations you face (e.g., lifting, stairs, driving) _______________________________

____

Are you presently involved in any other form of health care? ☐ YES ☐ NO

If YES, please specify _________________________ Name of Practitioner _________________________

Exercise Habits / Sports Played: ____

Regular Sleep Patterns? ☐ YES ☐ NO Working Hours ______________________

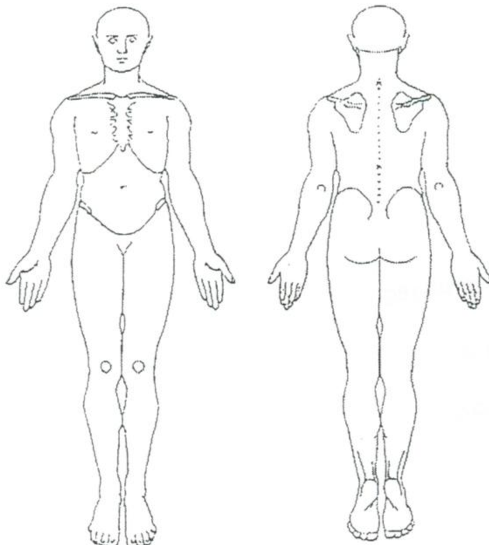
Accidents / Injuries / Surgeries (please be sure to note any pins, wires, plates, artificial joints):

____ ______________________
(type) (date)

____ ______________________

____ ______________________

On the diagram provided, please indicate where you feel the pain or tenderness with an X, and where you feel numbness or tingling with a Y:



Check the boxes that best describe the quality of your pain:

☐ Sharp	☐ Deep
☐ Superficial	☐ Constant
☐ Intermittent	☐ Shooting
☐ Burning	☐ Localized
☐ Not Local	☐ Aching
☐ Dull	☐ Throbbing

On a scale of 0 (no pain) to 10 (worst pain), where do you feel your current level of pain?____________________

What increases your pain? ______________

____

What decreases your pain? ______________

____

Please check the conditions that you are currently experiencing, or have experienced often in the past:

GENERAL
- ☐ Cancer
- ☐ Dizziness
- ☐ Depression
- ☐ Ear ache / Ear problems / Hearing Loss
- ☐ Epilepsy
- ☐ Eye pain / Eye problems / Vision Loss
- ☐ Fainting
- ☐ Fatigue
- ☐ Headaches / Migraines
- ☐ Hemophilia
- ☐ Numbness / Tingling
- ☐ Loss of sleep
- ☐ Nervousness / Anxiety
- ☐ Neuralgia
- ☐ Unusual Weight Loss / Gain

GENITO-URINARY
- ☐ Fecal Leakage
- ☐ Frequent Urination
- ☐ Kidney Conditions
- ☐ Prostrate Problems
- ☐ Prolapse
- ☐ Urinary Leakage

SKIN
- ☐ Bruise Easily
- ☐ Skin Eruptions/ Rash
- ☐ Warts
- ☐ Infectious Condition
- ☐ Eczema
- ☐ Psoriasis
- ☐ Other ___________

MUSCULOSKELETAL
- ☐ Arthritis / Type: _________
- ☐ Neck
- ☐ Shoulders
- ☐ Arm: Left / Right
- ☐ Upper Back / Middle Back
- ☐ Low Back
- ☐ Leg: Left / Right
- ☐ Knee: Left / Right
- ☐ Other ___________

DIGESTIVE
- ☐ Abdominal Pain
- ☐ Belching / Gas
- ☐ Colitis / Crohn's Disease
- ☐ Constipation
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Hernia
- ☐ Irritable Bowel Syndrome
- ☐ Liver / Gall Bladder
- ☐ Nausea
- ☐ Ulcers
- ☐ Other ___________

INFECTIOUS
- ☐ Hepatitis / Type: _____
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Other ___________

RESPIRATORY
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Smoking
- ☐ Breathing Problems / Type: _______________
- ☐ Allergies with anaphylactic response ______________
- ☐ Asthma
- ☐ Sinus Infections
- ☐ Difficulty Breathing
- ☐ Bronchitis

CARDOVASCULAR
- ☐ Angina
- ☐ Anemia
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Heart Condition
- ☐ Heart Disease
- ☐ High / Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Sensitivity to Heat / Cold
- ☐ Swollen Ankles
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Other ___________

WOMEN
- ☐ Currently pregnant

Number of Pregnancies ________
Delivery Type: ☐ Vaginal ☐ Cesarean
Ages of Children: ___________
- ☐ Nursed in the Past
- ☐ Currently Nursing
- ☐ Diastasis
- ☐ Menopause
- ☐ Other _______________
- ☐ Complications during any pregnancy or delivery: ________________________

Current Medications (please note what they are for) ____

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For massage clients: Have you had previous massage experience? ☐ YES ☐ NO