HEALTH HISTORY QUESTIONNAIRE

Information for your Massage Therapist & Osteopath

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a major role in diagnosis and treatment.
All information is strictly confidential.

I. GENERAL PATIENT INFORMATION Date: ____/____/_____

Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____

Email address: _____

To retain your health care privacy, may we contact you at these phone numbers? Yes No
If No, what is the best way to reach you to retain your privacy? _____

Age: _____ Date of Birth: _____/_____/_____ Place of Birth: _____

Guardian (if under 18 years of age): _____

Gender: □M □F Height: ____'____" Weight: _____ lbs. Marital Status: _____

Occupation: _____ Employer: _____

How did you hear about our office? _____

Family Physician: _____ Phone: _____

Insurance Company: _____

Emergency Contact Name, Phone Number and Relation to Patient:

Have you ever been treated by osteopathy before? Yes No

Main Conditions you would like us to help you with, in order of significance:

1. 4.

2. 5.

3. 6.

How long ago did these problem(s) begin, please be specific:
To what extent do these health problems affect your daily activities, such as work, sleep or hobbies?

What kinds of treatment have you tried, and how have they worked?

Have you been given a diagnosis for any of these problems, if so, what?

II. PAST MEDICAL HISTORY

Describe your childhood health: did you experience any ear infections, frequent colds, digestive disorders, allergies or any other health conditions?

Stress and Physical trauma causes and accelerates Blood Circulation problems.
Have you ever been in a car accident (even minor)? Yes No If yes, when? _____
Have you ever had a fall or sports injury? Yes No If yes, when? _____
Do you, or have you ever, worked at a desk or a computer? Yes No If yes, when? _____
Do you, or have you ever, had to do repeat lifting? Yes No If yes, when? _____

Have you ever been hospitalized? Yes No If yes, please explain the circumstances:
_____
Have you ever had surgery? Yes No If yes, please list all surgeries and dates:
_____
Please list any Allergies (food, seasonal, environmental):
_____

Recent Tests (Please indicate test results and date):

Physical Cholesterol Prostate Blood (which) HIV/STD

Pap Smear Mammography Other: _____

Test Results and Date: _____

Circle any you have had in the past:

Diabetes	Allergies	Glaucoma	Rheumatic Fever	Heart Disease	CVA (Stroke)
Vein condition	Asthma	Pneumonia	Tuberculosis	Emphysema	Mumps
Jaundice	Gonorrhea	Syphilis	Bleeding Tendency	Measles	High Fever
Meningitis	Chicken Pox	Epilepsy	Nervous Disorder	High Fever	Hepatitis
Mononucleosis	HIV/AIDS	Polio	Thyroid Disorder	Paralysis	Cancer
Migraines	Diabetes	Hepatitis	High Blood Pressure	Lung Disorder	Liver Disorder

Kidney Disorder Spleen Disorder Stomach Disorder Other:

Family Medical History: Please circle all that apply in your immediate family:

Cancer	Diabetes	High Blood Pressure	Stroke	Seizures	Allergies
Asthma	Heart Disease	Other Major Illnesses: _____			

III. PATIENT PROFILE

Prescription and over-the-counter medications cause various side effects, hide the severity of your health problems and hinder the body's ability to heal. Please list ALL the medications you are taking, or have recently taken, what you are taking them for and what side effects you've noticed (please use back of page or additional paper if more space is needed):

Drug	What For?	Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How would you rate the overall stress levels in your life? ☐ Low ☐ Moderate ☐ High

Occupational Stress: During your current or previous work positions, have you experienced:
☐ Psychological Stress ☐ Chemical/Environmental Stress ☐ Physical Stress ☐ Other stress: _____

I currently exercise: ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Poor Posture leads to poor health and often indicates a circulation problem. How would you rate your posture? ☐ Excellent ☐ Good ☐ Okay ☐ Not Good ☐ Terrible

Are you on a restricted diet? Yes No If yes, describe:

How much water do you drink daily?

How many caffeinated drinks do you drink per week (coffee, tea, soda)?

Do you currently or have you ever smoked cigarettes? Yes No If yes, how many cigarettes per day and for how long?

Pain Conditions:
Indicate any areas of pain in the body and the location of any scars on the body:

Is the pain sensation:
Sharp Burning Aching Cramping Dull Moving Fixed Other:

Do any of the following lessen the pain:
Pressure Cold Heat Exercise Other:

Do any of the following worsen the pain:
Pressure Cold Heat Exercise Other:

Please carefully complete the following section so that we may have a better understanding of your health status and the stress that your body has previously had or currently is experiencing.

Overall Temperature Please check off any that you have experienced in the past 12 months):
☐ Hot body temperature or sensation ☐ Cold hands ☐ Sweaty hands ☐ Afternoon flushes
☐ Cold body temperature of sensation ☐Cold feet ☐ Sweaty feet ☐ Night sweats
☐ Heat in the hands, feet and chest ☐ Hot flashes any time of the day ☐ Lack of perspiration
☐ Perspire easily ☐ Strong Thirst: if yes, do you thirst for hot or cold drinks?

Overall Energy Please check off any that you have experienced in the past 12 months):
☐ Difficulty keeping eyes open in the daytime ☐ Shortness of breath ☐ General weakness
☐ Easily catch colds ☐ Low Energy ☐ Feel worse after exercise

Heart Function: Please check off any that you have experienced in the past 12 months):
☐ Cardiovascular disease ☐ High blood pressure ☐ Low blood pressure
☐ Chest pain ☐ Fainting ☐ Palpitations ☐ Sores on tip of tongue
☐ Restlessness ☐ Anxiety ☐ Hard to fall asleep ☐ Wake unrefreshed
☐ Nightmares ☐ Restless sleep ☐ Mental Confusion ☐ Restless dreaming
☐ Waking during the night ☐ Chest pain traveling to shoulders or down arms ☐ Dizziness

Lung Function: Please check off any that you have experienced in the past 12 months):
☐ Profuse nasal discharge: ☐ thin/clear/runny ☐ thick white discharge ☐ thick yellow discharge
☐ Cough: Wet or Dry ☐ Nose Bleeds ☐ Sinus Congestion ☐ Dry mouth
☐ Dry, itchy throat ☐ Sore throat ☐ Dry skin ☐ Achy feeling in the body
☐ Sneezing ☐ Hives ☐ Stiff neck ☐ Stiff shoulders
☐Bronchitis ☐Rashes ☐Itching ☐ Eczema
☐ Dandruff ☐ Sadness ☐ Melancholy ☐Difficulty inhale or exhale
☐ Asthma ☐ Alternating fever and chills ☐ Smoke cigarettes/history of smoking
☐ Post Nasal Drip ☐ Loss of sense of smell ☐ Other Skin conditions: _____
☐ Allergies: list types of allergies, if known:

Spleen Function: Please check off any that you have experienced in the past 12 months):
☐ Low appetite ☐ Changes in appetite ☐ Cravings, for what?
☐ Abrupt weight gain ☐ Abrupt weight loss ☐ Abdominal bloating
☐ Abdominal gas ☐ Stomach Gurgling ☐ Fatigue after eating
☐ Easily bruised ☐ Hemorrhoids ☐ Pensive/Over-thinking/ruminations
☐ Worry ☐ Prolapsed organs: which organ?

Spleen, Stomach, Large Intestine, Small Intestine Function: Please check off any that you have experienced in the past 12 months):

☐ Loose Stools ☐ Incomplete Bowel Movements ☐ Constipation ☐ Acne
☐ Diarrhea ☐ Blood in Stools ☐ Undigested food in stools
☐ Mucous in stools ☐ Black or tarry stools ☐ Chronic use of laxatives: what type of laxatives

Dampness/Mucous trapped in body: Please check off any you have experienced in the past 12 months):

☐ General sensation of heaviness in body ☐ Mental heaviness ☐ Mental sluggishness
☐ Mental fogginess ☐ Swollen hands ☐ Swollen feet ☐ Swollen joints
☐ Chest congestion ☐ Nausea ☐ Snoring ☐ Sinusitis/Sinus Congestion
☐ Dizziness ☐ Phlegm production ☐ Pain or any symptoms worse in damp/rainy weather

Stomach Function: Please check off any that you have experienced in the past 12 months):

☐ Burning sensation after eating ☐ Large appetite ☐ Bad breath ☐ Vomiting
☐ Sores on lips, tongue or mouth ☐ Ulcer (if diagnosed) ☐ Belching ☐ Acid regurgitation
☐ Cold sensation in stomach ☐ Hiccoughs ☐ Stomach Pain ☐ Heartburn
☐ Bleeding, swollen or painful gums ☐ Acne

Liver and Gallbladder Function: Please check off any you have experienced in the past 12 months)

☐ Chest pains ☐ Tight sensation in chest ☐Bitter taste in mouth
☐Anger easily ☐Frustration ☐Depression
☐Irritability ☐Skin rashes ☐Tingling sensations
☐Numbness ☐Muscle Spasms ☐Muscle Twitching
☐Muscle Cramping ☐Seizures ☐Convulsions
☐Lump in throat ☐Teeth Grinding ☐Alternating diarrhea and constipation
☐Neck tension ☐Shoulder tension ☐Hip pain/Sciatica
☐ Drink alcohol ☐ Gallstones, history of or currently? ☐ Sensation of a lump in throat
☐ Genital sores ☐ Recreational drug use ☐ High pitch ringing in the ears
☐ Sexually transmitted diseases: which? _____
☐ Frequently unable to adapt to stress (what causes this stress?) _____
☐ Headaches ☐ Migraines
How often do you experience headaches? _____ Describe the location of headaches:

Eyes/Liver Function: Please check off any that you have experienced in the past 12 months):

☐ Itchy ☐ Red or Bloodshot ☐ Hot ☐ Dry
☐ Watery ☐ Gritty or sandy feeling ☐ Blurry vision ☐ Decreased night vision
☐ Near-sighted ☐ Far-sighted ☐ Cataracts ☐ Visual Disturbances
☐ See floaters or floating black spots in the eyes ☐ Other Eye Problems: _____

Kidney Function: Please check off any that you have experienced in the past 12 months):

☐ Frequent cavities ☐ Easily Broken Bones ☐ Poor hearing ☐ Earaches
☐ Painful knees ☐ Weak knees ☐ Cold in knees ☐ Low back pain
☐ Memory problems ☐ Excessive hair loss ☐ Pre-mature grey hair ☐ Low-pitch ringing in the ears
☐ Kidney stones ☐ Bladder/Urinary tract infections ☐ Fear ☐ Easily startled
☐ Foot weakness or pain ☐ Ankle Weakness or Pain ☐ Lack bladder control ☐ Sneeze/ jump incontinence

Urination: Please check off any that you have experienced in the past 12 months):

How many times per day do you urinate?

Do you wake during the night to urinate? Yes No If yes, how many times per night? _____

□ Normal color urine	□ Dark yellow	□ Clear	□ Reddish
□ Cloudy	□ Scanty	□ Profuse	□ Strong Odor
□ Burning	□ Painful	□ Difficult	□ Urgent

Libido: (Blood circulation problems to the genitals can cause libido problems. Libido is a sign of overall health and vitality.) Is your libido: □ Low □ Normal □ Too High

MEN ONLY:

Blood circulation problems to the male genitalia can cause the following function problems. Please check off any that you have experienced.)

□Swollen testes □Testicular pain □Impotence □Premature ejaculation

□Feeling of coldness or numbness in external genitalia □Other_____

WOMEN ONLY:

Do you currently, or have you ever used any birth control pills/patches? Yes No If yes, please list types and dates of use: _____

Do you currently practice other methods birth control? If yes, please list all types of birth control used and dates of use: _____

How often do you experience vaginal discharge? _____

What is the typical color and consistency of your discharge? _____

Do you experience any odor with the discharge? _____

Do you have a regular, 28 day menstrual cycle? □Yes □No If No, what is the average number of days of the entire cycle? _____

On average, how many days do you experience blood flow in the cycle: _____

Do you experience any uterine bleeding outside of the menses, or spotting between periods? □Yes □No

If yes, how much and how often? _____

What was the age of your first menstrual cycle? _____

What was the age of menopause onset (if applicable): _____

Proper blood flow and circulation is especially important during pregnancy, is there any chance you may be pregnant now? □Yes □No

Number of children_____ Number of pregnancies: _____

Blood circulation problems in the uterus can cause the following menstrual problems. Do you experience any of the following pre-menstrual syndromes?

□ Nausea	□ Vomiting	□ Water retention	□ Breast swelling	□ Acne
□ Food cravings	□ Headaches	□ Migraines	□ Breast tenderness	
□ Depression	□ Irritability	□ Anxiety	□ Other: _____	
□ Dull pain, where? _____		□ Sharp pain, where? _____		

PATIENT HEALTH ASSESSMENTS:

Please describe your Average Daily Diet, listing common foods consumed at meals:

Breakfast Lunch Dinner Snacks

How would you rate your health at the following categories? (1 = bad, 10 = perfect)

ENERGY LEVELS (without caffeine or other stimulants)	1 2 3 4 5 6 7 8 9 10
MENTAL CLARITY (without caffeine or other stimulants)	1 2 3 4 5 6 7 8 9 10
SLEEP QUALITY (how refreshed you feel in the morning)	1 2 3 4 5 6 7 8 9 10
FLEXIBILITY (ease of movement)	1 2 3 4 5 6 7 8 9 10
OVERALL HEALTH	1 2 3 4 5 6 7 8 9 10

If you keep doing the same things you are doing, and fail to make proper changes, what do you see happening to your health in the next FIVE YEARS?

☐ Spontaneous Improvement ☐ Stay the same ☐ Gradually worsen

What is your goal and objective for your care in our office?

☐ Pain/symptom relief only ☐ Full Correction of the problem ☐ Optimal health and wellness

If our office can really impress you with our service and your clinical results, would you be willing to send to us our family, friends and co-workers for a Free Initial Health Consultation? Yes No

If no, what would stop you? _____

Please tell us of any other problems you would like to know about your health or issues you would like to discuss: _____

_____

_____

_____

_____

I herby give consent for treatment, I understand I have the right to stop treatment at any point. I understand the possible benefits and side effects of treatment. Any question that may arise concerning the treatment will be answered. I understand that failure to cancel an appointment prior to 24 hours of the treatment time will result in a charged appointment.

Patient / Gaurdian Signature: _____ Date:_____

CANCELLATIONS WITHIN 24 HOURS OF TREATMENT WILL BE CHARGED

APPENDIX A: CONSENT FORM

SUBJECT CONSENT FORM

I AGREE TO PARTICIPATE AS A SUBJECT FOR THE OSTEOPATHIC STUDY ENTITLED:

NEUROCOGNITIVE EFFECT OF CRANIAL OSTEOPATHY

WITHIN A CONCUSSED POPULATION

I,_____ UNDERSTAND THAT PARTICIPATING IN THIS STUDY:

(1) I WILL BE REQUIRED TO COMPLETE FOUR CONSECUTIVE TREATMENTS FOR CONCUSSIONS WITH A THERAPIST ONE WEEK APART;

(2) I WILL COMPLETE, IN FULL, THE IMPACT © TEST PRIOR TO EACH TREATMENT AND FOUR WEEKS POST TREATMENT;

(3) I WILL INFORM THE STUDY CONTACT PERSON IF ANY OF THE RECORDED INFORMATION CHANGES THROUGHOUT THE STUDY;

(4) I UNDERSTAND THAT SYMPTOMS MAY CHANGE, GET WORSE OR BETTER DURING THE STUDY AND AM TO ADVISE THE THERAPIST OF ANY CHANGES;

(5) I AM AWARE THAT, IF AT ANY TIME I WISH TO WITHDRAW FROM PARTICIPATING IN THE STUDY, I MAY DO SO AT NO DETRIMENT TO MYSELF;

(6) I AM AWARE THAT THE INFORMATION DERIVED FROM THE PARTICIPATING IN THIS STUDY WILL BE STRICTLY CONFIDENTIAL BUT MAY BE UTILIZED FOR RESEARCH PUBLICATIONS AND FOR THESIS PROJECT. I WILL NOT BE IDENTIFIED IN ANYWAY, BUT THE RESULTS GROUPED.

NAME OF PARTICIPANT/GUARDIAN_____

SIGNATURE OF PARTICIPANT/GUARDIAN_____ DATE:_____

NAME OF WITNESS_____

SIGNATURE OF WITNESS_____ DATE:_____

NAME OF STUDY COORDINATOR_____

SIGNATURE OF STUDY COORDINATOR_____ DATE:_____

Appendix B: Concussion History Questionnaire

Concussion History Questionnaire

1. How many diagnosed concussions have you had?
    1. 0
    2. 1
    3. 2
    4. 3
    5. 4 or more
2. Have you ever lost consciousness from a concussion before?
    1. no
    2. yes, less than a minute
    3. YES, between a minute and five minutes
    4. yes, greater than five minutes
    5. not sure
3. Have your symptoms increased in severity since your trauma?
    1. Yes
    2. NO
4. Increasing activity level increases symptoms?
    1. Yes
    2. No
5. Trouble concentrating when reading
    1. Yes
    2. No
6. Increase in symptoms when exposed to lights
    1. Yes
    2. No
7. Increase in symptoms when exposed to noise
    1. Yes
    2. No

8. TROUBLE SLEEPING?
    1. YES
    2. NO
9. LOSS OF APPETITE?
    1. YES
    2. NO