Sage Wellness Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone #:_____

Address:_____ E-mail address:_____

_____Occupation:_____Date of Birth:_____

Have you received athletic therapy before? Yes__ No__

Did a Health care practitioner refer you for athletic therapy? Yes__ No__

If yes, please provide their name and address:_____

Please indicate below the conditions you are experiencing or have experienced:

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis/varicose veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease

Is there a family history of any of the above? Yes__ No__

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Is there a family history of any of the above? Yes__No__

Infections

- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions

- ☐ Loss of sensation, Where?_____
- ☐ Diabetes, onset:_____
- ☐ Allergies/hypersensitivity,to what?
- ☐ _____
- ☐ Type of reaction:_____
- ☐ Epilepsy
- ☐ Cancer, where?_____
- ☐ Skin conditions, what?_____
- ☐ _____
- ☐ Arthritis

Is there a family history of arthritis? Yes__ No__

Head/Neck

- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss
- ☐ Jaw problems/pain

Pregnant, due:_____

Gynaecological conditions, What?_____

How is your general health?

_____

Primary Care Physician:

_____

Address:_____

_____

_____

_____

Current Medications:

_____

Condition Treated:

_____

Are you currently receiving treatment from another health care professional? Yes__ No__

If yes, for what?_____

_____

Surgery – date:_____

Nature:_____

Injury – date:_____

Nature:_____

Do you have any other medical conditions (eg digestive conditions, haemophilia, osteoporosis, mental illness) Yes__ No__

What?_____

Do you have any internal pins, wires, artificial joints, or special equipment? Yes__ No__

What?_____

Where?_____

What is the reason you are seeking athletic therapy? Please include the location of any tissue or joint discomfort.

_____

_____

☐ It is ok for Sage Wellness to contact me at the contact information I have provided above.

Date of Initial Health History:_____

Update 1:_____

Update 2:_____

Update 3:_____

Update 4:_____