GENERAL HEALTH HISTORY

Note: Information provided is for therapeutic purposes only and remains strictly confidential

First name:	Last name:	Age:	Occupation:
Address:	Postal code:	City:	
Phone: Home: ( )	Work: ( )	Cell: ( )	
Date of birth: d d m m y y y y	Physician:	How did you hear about our clinic:	
Email:			

I would like to receive a confirmation of my upcoming appointments by email. *	☐ Yes	☐ No

** Please note that this courtesy service is automated and may be subject to some technical difficulties. Alternatively, it is possible to request a confirmation of your next appointment by phone by specifying it to the receptionist.*

- Reason for consultation: ______________________________
- Sports and leisure activities : ______________________________
- Treatment received for current condition:

☐ Acupuncture	☐ Osteopathy	☐ Physiotherapy	☐ Massage therapy	☐ Chiropractic

- Check the following conditions that apply to you, past and present:

Skin
- ☐ Allergies
- ☐ Psoriasis

Ears
- ☐ Hearing impairment
- ☐ Vertigo/dizziness
- ☐ Tinnitus

Noze
- ☐ Sinusitis
- ☐ Sense of smell

Throat / Mouth
- ☐ Pain while swallowing
- ☐ Major dental work
- ☐ Teeth grinding /Tightness or creaking of jaw

Cardio-vascular
- ☐ High / low blood pressure
- ☐ Pacemaker
- ☐ Heart condition
- ☐ Stroke

Pulmonary
- ☐ Asthma
- ☐ Bronchitis / Pneumonia
- ☐ Difficulty breathing
- ☐ Smoker

Digestive
- ☐ Abdominal pain
- ☐ Gas / Bloating
- ☐ Gastric reflux
- ☐ Heartburn
- ☐ Hiatus hernia
- ☐ Irritable bowel syndrome
- ☐ Constipation / Diarrhea
- ☐ Other: ______________

Past surgery:	Year:

Neurology
- ☐ Tingling / Numbness
- ☐ Decreased sensitivity
- ☐ Muscular weakness
- ☐ Head trauma / Loss of consciousness
- ☐ Epilepsy
- ☐ Headaches / Migraine

Endocrinal
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Diabetes / Hypoglycemia
- ☐ Osteoporosis / Arthritis
- ☐ Recent weight loss / Weight gain
- ☐ Menopause

Other conditions:
- ☐ Cancer
- ☐ Depression
- ☐ ______________
- ☐ ______________

Current medication (includes prescription and over-the-counter):	

Signature :	Date : d d m m y y y y

*** Signature also required on back page ***

Cancellation policy

If you need to cancel or reschedule, we require that you do so by phoning us 24 hours prior to the date of your appointment.

Since your therapist is paid by the act, he will not be paid during a missed appointment. Thus, this 24 hours gives us the opportunity to offer this time slot to another patient.

If an unmotivated absence occurs, or if the appointment was not cancelled within the required time, 30% of the treatment cost will be billed to you.

I have read and understand Centre TMO's cancellation fee policy.

Signature: ______________________________ Date: ________________

Centre **TMO** - Centre de **T**hérapies **M**anuelles et **O**stéopathiques de Hull

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