Medical History

Privacy: In accordance with the Osteopaths' Code of Professional Conduct, the confidentiality of your information is strictly maintained. Your records are stored securely, and information about you will not be divulged without your permission (unless required by law).

○ Mr ○ Mrs ○ Sister
○ Ms ○ Dr ○ Fr
○ Miss ○ Prof ○ Other…

Given Name ..... **Family Name** .....

Street address .....

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Suburb or town ..... **Postcode** .....

Home phone ..... **Work phone** .....

Mobile ..... **Email** .....

Date of birth .....

How much excercise, and of what type, do you take per week?

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Daily activities (e.g. occupation, sports, hobbies)

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What significant accidents have you had, and when were they?

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When have you been in hospital, and what were you there for? (Please include giving birth.)

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Have you had any major illnesses, and if so, what and when were they?

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What medications are you on or have you been taking recently? Have you previously been on any long-term medication?

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Have you had any dental work in the past two months?

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Do you smoke?

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How would you describe your diet? Is there anything you don't eat?

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What conditions run in your family? (e.g. high blood pressure, heart conditions, cancer, diabetes, arthritis)

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Medical History

Do you, or have you recently, suffered from any of the following?

Musculo-skeletal system

☐ Lower back pain ☐ Upper back pain ☐ Shoulder pain ☐ Other joint stiffness ☐ Deep bone pain
☐ Mid back pain ☐ Neck pain ☐ Other joint pain ☐ Joint swelling ☐ Other…

Cardio-vascular system

☐ Chest pain ☐ Racing or irregular heart beat ☐ Cold or blue fingers
☐ Fainting or loss of consciousness ☐ Shortness of breath ☐ Changes to finger nails
☐ High blood pressure ☐ Fluid retention or ankle swelling ☐ Other…

Respiratory system

☐ Pain on breathing ☐ Persistent or recurrent sore throats ☐ Sinus pain
☐ Persistent cough ☐ Ear aches or ear infections ☐ Sinus congestion
☐ Persistent or frequent colds or respiratory infections ☐ Asthma ☐ Other…

Reproductive system (women)

☐ Painful periods ☐ Difficulty conceiving ☐ Are you or could you be pregnant?
☐ Unusual bleeding ☐ Miscarriage ☐ Other…
☐ Irregular periods ☐ Pain or difficulty on intercourse

Reproductive system (men)

☐ Difficulty achieving or maintaining erection ☐ Lump in testicle ☐ Other…
☐ Pain in testicles ☐ Diminished fertility

Urinary system

☐ Pain on urination ☐ Difficulty starting flow or incomplete emptying ☐ Other…
☐ Unexplained discharge ☐ Incontinence or leakage

Endocrine (hormonal) system

☐ Tremors ☐ Changes of appetite ☐ Unexplained swellings ☐ Hot flushes
☐ Excessive thirst ☐ Unexplained weight loss ☐ Tiredness or lethargy ☐ Other…
☐ Excessive need to urinate ☐ Unexplained weight gain ☐ Excessive perspiration

Nervous system

☐ Dizziness or difficulty with balance ☐ Migraines ☐ Changes in hearing or tinnitus ☐ Numbness
☐ Headaches ☐ Visual disturbances ☐ Tingling or altered sensations ☐ Other…

Gastro-intestinal system

☐ Difficulty swallowing ☐ Ulcer ☐ Frequent diarrhea ☐ Bloating
☐ Indigestion, heart-burn or reflux ☐ Change in bowel habits ☐ Frequent constipation ☐ Other…
☐ Gall-bladder problems ☐ Intestinal pain ☐ Nausea

Immune system

☐ Hayfever ☐ Psoriasis ☐ SLE ☐ Anaphylactic reactions ☐ Other auto-immune disease
☐ Asthma ☐ Rheumatoid arthritis ☐ Crohn's disease ☐ Other allergies ☐ Other…

Psychological

☐ Depression ☐ Anxiety ☐ General irritability ☐ Feeling stressed ☐ Other…

Sleep health

☐ Trouble getting started in the morning ☐ Trouble getting to sleep at night
☐ Over-tired during the day ☐ Trouble staying asleep in the early morning
☐ Over-tired in the evening ☐ Other…

How is your energy level?

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Have you had manual therapy (e.g. osteopathy, chiropractic, physiotherapy, massage, Bowen therapy) before, and, if so, was there any aspect of your treatment that you particularly liked or disliked?

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Is there anything else important in your medical history?

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Medical History

What are your health goals?

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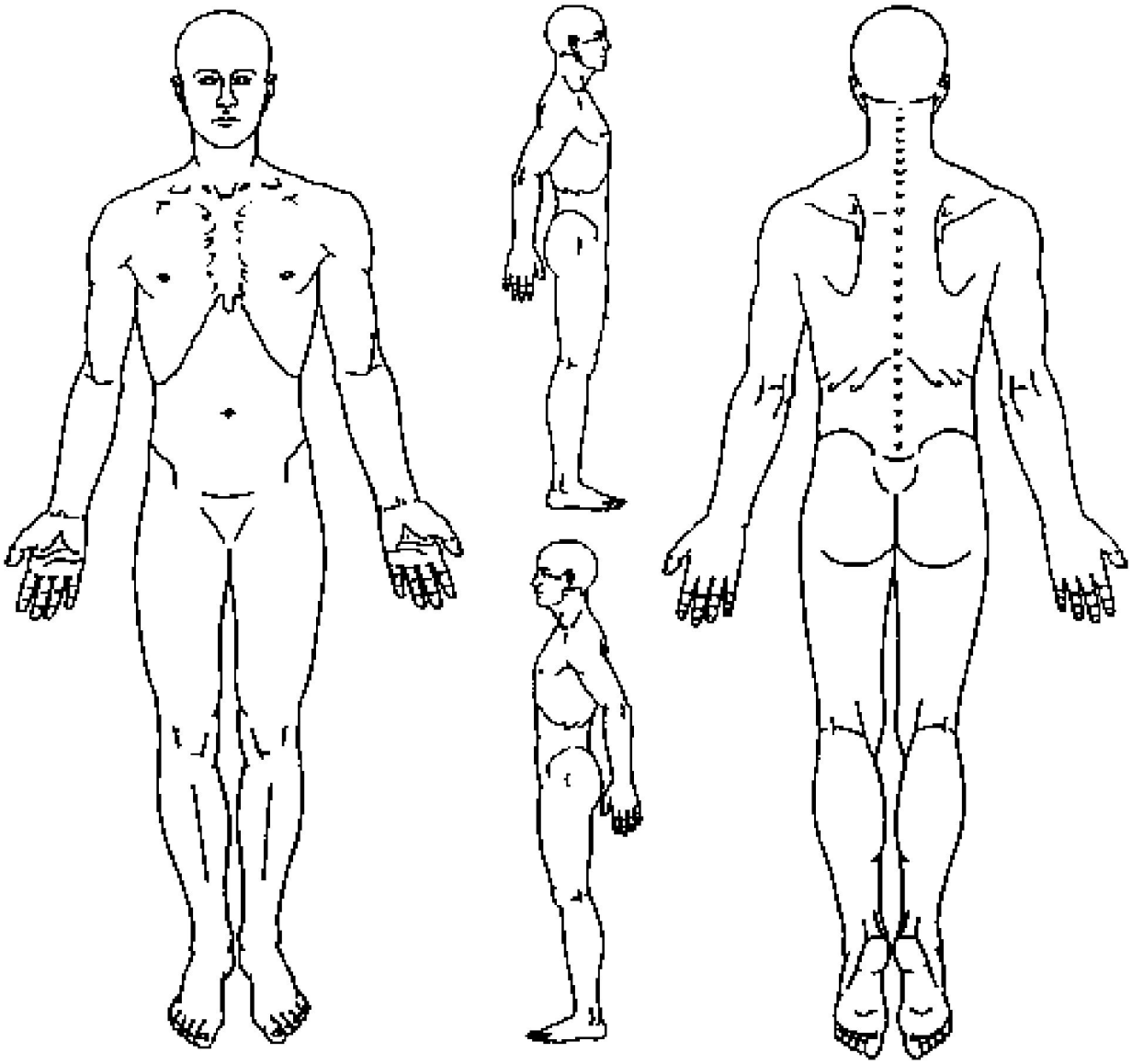
Please draw your pain on this diagram. You can use some of these symbols if you find it helpful; otherwise just scribble:

X = general pain
O = stiffness
| = numbness, tingling, cold ache or something else that feels like nerve pain
^ = sharp stabbing
? = something hard to describe



How long have you had your pain? ..... years ..... months ..... days