

Innercore Health
 57 York Street- Unit 5. London, Ontario
 N6A 1A6
 519 432-7247

Health History Form – page 1

An accurate health history is important to ensure that it is safe for you to receive treatment. All information gathered is confidential except as required or allowed by law. At times when multiple therapists are treating the same patient, files and information will be shared to allow the best delivery of health care. Written authorization will be required for release of any information.

Name: _____ Sex: F _____ M _____
 Telephone Res: _____ Bus: _____
 Address: _____ City _____ Postal Code _____
 Date of Birth: _____ Occupation: _____ Hobbies: _____
 Email: _____

Is this your first time receiving this type of therapy (i.e. chiropractic, massage, physiotherapy, athletic therapy, nutrition counseling, acupuncture)? YES / NO

Reason for treatment today: _____

Please indicate conditions you are experiencing or have experienced in the past, using a ✓, or fill in box appropriately.

Soft Tissue/Joints	Respiratory	Skin	Genitourinary
Neck	Chronic cough	Skin condition/specify:	Prostate
Shoulder	Shortness of breath	Bruise easily	UTI
Upper back	Bronchitis	Herpes	Painful urination
Low back	Asthma	Varicose veins	
Arms	Emphysema	Athletes foot	Women's Health
Legs	Pneumonia	Loss of sensation	Painful menstruation
Knees	Sinus problems	Other	Irregular menstruation
Hip	Other		Currently on birth
Other		Other conditions	control pill Y / N
	Cardiovascular	Neurological	Number of pregnancies
Headaches	High blood pressure	Epilepsy	Number of children
Tension	Low blood pressure	Diabetes Type:	Reg. breast exams Y / N
Migraine	Heart disease	Allergies	Reg. pelvic exams Y / N
Tooth/jaw/ear pain	Phlebitis	Cancer	
Head trauma/date:	Stroke/CVA	Arthritis	
Other	Heart attack	Type: OA /RA / other	
	Pacemaker	Where?	
Accidents/Injuries	Angina	Vision problems	
Car accident/date:	Congestive heart failure	Hearing conditions	
Work related/date:	Other	Digestive problems	
Symptoms:		Sleep disturbance	
Physical Limitations:	Infectious disease	Hemophilia	
	Hepatitis	Depression	
	HIV	Other	
	Tuberculosis		
	Other		

Primary Practitioner: Dr. Ken Hou

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Health History Form – page 2

Name: _____

Name of Primary Physician _____ Phone number _____

Previous Surgery: Y / N Type/Date _____

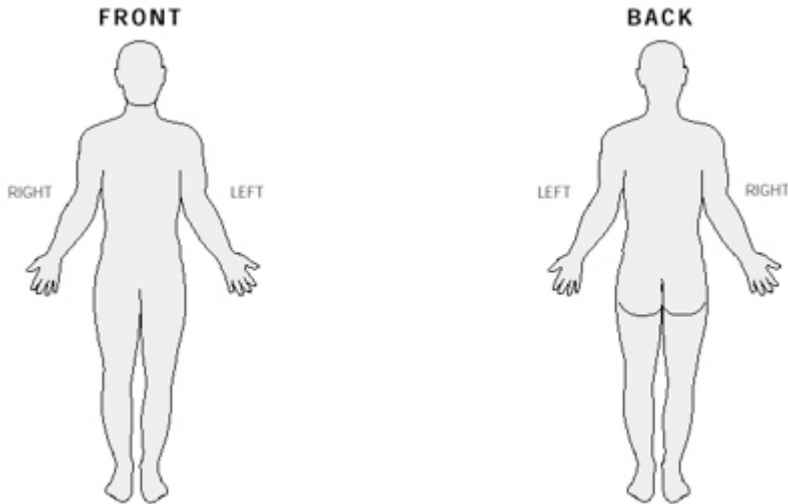
Current medications/supplements _____

Allergies _____

Present use of other health care: Y / N Please specify _____

Current symptoms _____

Please use this space to elaborate on any of the above or other conditions, if needed.



Use this diagram to show where you have your pain. Mark the area with the symbol that best describes your pain:

- Aching Pain *****
- Burning Pain xxxxxxxx
- Numbness =====
- Pins and needles OOOOO
- Stabbing pain /////

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Patient Waiver

Fee

The patient is responsible for paying at the end of each treatment. This fee may be reimbursed by your extended health plan. Please refer to our fee schedule for the cost of each service.

Cancellations with less than 24 hours notice will be charged \$10.00. This will be charged to you automatically.

I hereby release and hold harmless Innercore Health and Dr. Ken Hou, its officers and employees and affiliated associates from any liability with the respect to injury of any nature to me or my property related to any therapy, treatment or exercise participation. I acknowledge that Innercore Health and Dr. Ken Hou offers no guarantee or warranty, written or unwritten, that its services will have any beneficial effect on the client or that its services or advice have been or are approved by any medical authority.

I have read the above information and have stated all of my previous and current medical conditions. I take it upon myself to update my therapist regarding any changes in my condition. I understand that all treatments will be discussed and planned with the respective therapist, and will require my informed consent.

Patient Name: _____

Signature: _____

Date: _____

Thank you for your patience and cooperation in filling out this form.

Primary Practitioner: Dr. Ken Hou

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INITIAL HISTORY AND EXAMINATION FORM

HISTORY

Physical Examination

Primary Practitioner: Dr. Ken Hou