Innercore Health
500 Oxford Street East
N5Y 3H7
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					

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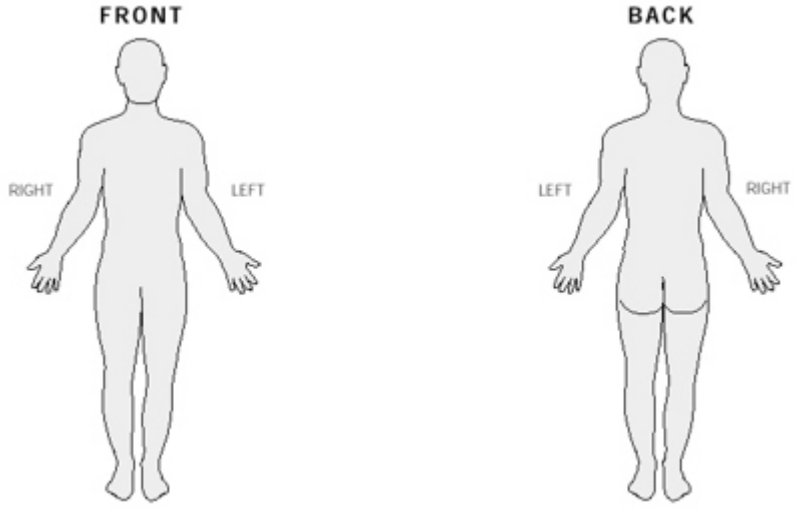
Health History Form – page 2

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