TOUCHMATTERS MANUAL THERAPY
Health History Form

The information that you are providing on this form will give me the necessary starting point to help you with your primary complaint. Please be as thorough as you can, if there is something that you feel I should know about your health history and there is no space for it on the form please add it to the last page. When I meet with you we will go over the information that you have provided and gather more detail if needed.

NAME:_____ DATE:_____

ADDRESS:_____
(street and number) (city) (postal code)
TELEPHONE:

_____

(home) (work) (cell)

DATE OF BIRTH: _____OCCUPATION: _____

DOCTORõS NAME: _____ PHONE # _____

EMAIL ADDRESS:_____

WHO REFERRED YOU TO ME FOR CARE?_____

Please check off the conditions that you currently experience

CARDIOVASCULAR
- high blood pressure /
- low blood pressure /
- angina
- heart disease
- rheumatic fever
- phlebitis
- chest pains
- stroke
- varicose veins
- poor circulation

RESPIRATORY
- shortness of breath
- chronic cough
- bronchitis
- pneumonia
- sinusitis
- tuberculosis
- asthma / emphysema
- smoker (light / heavy)
- allergies

(food ,nuts, perfumes _____)

INFECTIONS
- herpes
- warts
- frequent colds
- frequent fluõs
- other

_____
- auto immune disease

_____
- athletes foot
- candida
- cold sores

DIGESTIVE /UROGENITAL
- poor appetite
- regular meals
- bloating /difficult digestion
- constipation
- diarrhea
- liver dysfunctions
- gall bladder dysfunctions

MUSCULAR / JOINTS
- neck pain/stiffness (L / R)
- face pain (L / R)
- head pain (L/ R/ front/ back)
- TMJ pain/stiffness (L /R)
- shoulder pain/stiffness (L / R)
- arm pain/stiffness (L / R)
- hand pain/stiffness (L / R)

□ diabetes
□ IBS diagnosis
□ celiac disease
□ crohns disease
□ colitis
□ bowel movements (per day)
□ 1 □ 2 □ 3 □ more

SKIN
□ acne
□ herpes
□ fungal infections
□ scars
□ rashes
□ eczema
□ psoriasis

□ easily bruised
□ impaired skin sensation
□ skin infection of any kind
□ topical medications

□ other
_____

NERVOUS SYSTEM
□ sciatica
□ thoracic outlet syndrome
□ carpal tunnel syndrome
□ shingles
□ neuritis
□ neuralgia
□ racing heart □ slow heart
□ any of the above doctor diagnosed
□ numbness □ tingling

□ pins / needles

□ back pain/stiffness (upper, middle, lower)
□ pelvis/hip pain/stiffness (L / R)
□ upper legs pain/stiffness (L / R)
□ knees pain/stiffness (L / R)
□ lower leg pain/stiffness (L / R)
□ ankle/foot pain/stiffness (L / R)
□ osteoarthritis _____
□ osteoporosis _____
□ rheumatoid arthritis _____
□ fractures _____
□ implants: pins, wires screws, other _____

HEAD / FACE
□ headaches (migraine / tension / cluster /sinus)
□ per day___ □ per week ___ □ per month ___
□ head trauma (Y / N)
□ face or head lacerations
□ concussion □ blow to head □ saw stars
□ dizziness □ forget details of injury □ low energy
□ more emotional □ constant headache
□ vision problems □ earaches □ ringing
□ eye pain □ dry eye □ excessive tearing
□ photosensitive
□ reduced hearing □ epilepsy □ nausea
□ vertigo /spinning sensation
□ vision problems □ contact lenses
□ dental history: □ extractions □ root canals □ implants
□ braces □ wisdom teeth extracted
□ broken teeth □ false teeth
□ gingivitis □ bad breath □ infections
□ repeated sinus infections □ face pain □ teeth grinding
□ teeth clenching □ night mouth guard

NUTRITION
□ vegetarian □ vegan
□ food restrictions
_____
□ food allergies
_____
□ supplements
_____

WOMEN
□ menstruation: □ painful □ heavy □ scant
□ pregnant □ # of children _____ □ miscarriage(s) _____
□ menopause (date) _____ □ bone density exam (date) _____
□ fractures □ hormone therapy □ gynecological surgeries _____

SURGERY

TYPES **DATE**

_____

_____

_____

_____

INJURIES

TYPES **DATE**

_____

_____

_____

MEDICATIONS

NAME **CONDITION BEING TREATED**

_____

_____

_____

OTHER HEALTHCARE PRACTITIONERS

☐ Chiropractor _____

☐ Naturopath / Homeopath _____

☐ Physiotherapy _____

☐ Psychotherapy _____

☐ Spiritual Direction _____

☐ Acupuncture _____

☐ Other _____

LIFESTYLE QUESTIONS

Please indicate which of the following you currently experience:

Increased fatigued in the morning
Fully awake after the noon meal
Salt cravings
Decreased libido
Experience muscle weakness
Experience absent mindedness
Low energy between 2 ï 4 pm
Feel better after 6 pm
Work best late into the night
PMS, peri-menopausal, menopause symptoms worse when experiencing stress
Need a coffee or other stimulant to ñget goingò in the morning
Feel overwhelmed in stressful situations
Feel better when on vacation
Pain between shoulders, upper back and neck
Often feel cold
Increase frequency of getting the flu
Increase frequency of getting respiratory infections
Slower to recover from infections
Dry thin skin

How long have you experienced these symptoms?
past 3 months past 6 months past 12 months or longer

_____
_____
_____
_____

Please indicate which of the following you currently experience.

You have noticed a decrease in your ability to concentrate.
You often feel: depleted, unrested, exhausted, angry, teary, physically sore.
(circle all that apply to you)
You often wake up with a morning headache.
You experience sleep apnea (holding your breath at night while sleeping)
You have been diagnosed with high blood pressure.
You have trouble falling to sleep (occasionally, frequently, always)
You fall asleep in less than 5 minutes
You toss and turn during the night
In the afternoon you feel tired, sleepy or have low energy
You have asthma _____
You notice that your legs are ñrestlessò at night and may keep you awake or wake you up
You have diabetes _____
You have noticed or others have, that your job performance has gone down
You snore at night when sleeping
You struggle with weight gain
You have been diagnosed with cardiovascular disease
You use a sleep aid to fall to sleep: (medication, herbals) _____
You experience depression : _____
(please indicate the medications used to manage this condition)
You take stimulants (medications, coffee) to help you stay awake
You feel hot or cold while you are trying to sleep
You experience insomnia

You have noticed a lower tolerance for alcohol
You take naps: (rarely, occasionally, frequently)
You notice that you experience sleepiness while driving your vehicle
When travelling by car you often donôt remember the journey
You have noticed that your eye-hand co-ordination is getting worse

How long have you been experiencing these symptoms?
past 3 months past 6 months past 12 months or longer

Women only complete this section

Hot flashes	Mood swings	Urinary incontinence
Heart Palpitations	Cystic ovaries	Vaginal dryness
Heavy Menses	Foggy thinking	Weight gain
Fibrocystic breasts	Irritability	Increased body/facial hair
Thinning skin	Uterine Fibroids	Night sweats
Acne	Depressed mood	Headaches
Bone loss		
Aches and pains	Elevated triglycerides	Allergic conditions
Sleep disturbances	Depression	Susceptibility to infections
Infertility	Nervousness	Bone loss
Chronic illness	Evening fatigue	Blood sugar imbalances
Morning fatigue	Anxiety	Auto immune illness
Aches and pains	Anxiety	Brittle nails
Dry skin	Cold hands and feet	Headaches
Fatigue	Foggy thinking	Weight gain
Heart palpitations	Low libido	Inability to lose weight
Constipation	Thinning hair	Menstrual irregularities
Depression	Feeling cold all the	Elevated Cholesterol
Infertility time	Sleep disturbances	

How long have you been experiencing these symptoms?
past 3 months past 6 months past 12 months or longer

_____
_____
_____
_____

Men only complete this section

Burned out feeling	Irritable	Infertility problems
Decreased urine flow	Hot flashes	Erectile dysfunctions
Oily skin	Apathy	Decreased stamina
Weight gain (waist)	Prostate problems	Sleep disturbances
Decreased libido	Decreased mental	Decreased muscle mass
Night sweats sharpness	Insomnia	
Increased urinary urge	decreased urine flow	Morning fatigue
Aches and pains	Elevated triglycerides	Anxiety
Sleep disturbances	Depression	Infertility
Bone loss	Blood sugar	Auto immune illness
Lack of motivation		Fibromyalgia
Prostate problems	Allergic conditions	Weight gain (waist)
Chronic illness	Evening fatigue	Stress
Prone to infections	Decreased erections	Lack of motivation
Low libido	Depression	Decreased erections
Foggy thinking	Infertility	Sleep disturbances
Constipation	Fatigue	Inability to lose weight
Elevated cholesterol	Cold body temp	Headaches

How long have you been experiencing these symptoms?

past 3 months	past 6 months	past 12 months or longer

_____
_____
_____

What are your goals for treatment? Please carefully consider the physical pains, aches, lack of mobility and any other limitations that you would like to see change. By specifying each issue you would like to see change, makes the sessions more effective and productive in reaching your goals.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Please indicate on this diagram where you experience pain or altered sensations.

Circle areas of pain.

Use hash lines for altered sensations