INTEGRATIVE THERAPEUTICS
MEDICAL HISTORY FORM

PLEASE COMPLETE THIS FORM IN FULL. ALL INFORMATION IS STRICTLY CONFIDENTIAL.
PLEASE PRINT.

Date:_____ ◉ **MALE** ○ **FEMALE**

Name:_____ **Age:**___ **Date of Birth:**_____
Last **First**

Resident Address:_____
Street **City**

Province:_____ **Postal Code:**_____ **Occupation:** _____

Resident Telephone Number:_____ **Cell / Business Number:**_____

General Practitioner:_____ **Address:**_____ **Phone Number:**_____

Date of Last Medical Examination:_____ **Referred By:**_____

List Any Past Surgeries including dates:

List Any Past Injuries/Accidents including dates:

Please List All Medications You Are Currently Taking or Have Taken In The Last Six Months

_____
Medication and Reason for Taking

_____
Medication and Reason for Taking

Are You Currently Undergoing Any Forms Of Treatment? **Please Detail.**

Do You Exercise Regularly (3 Times per Week) ○ **Yes** ◉ **No**

If You Experience Any Of The Following Symptoms During Or Shortly After Physical Activity Please Circle:

Extreme Muscle Soarness	**Difficulty Breathing**	**Headaches**	**Chest Pain**
Extreme Weakness/Fatigue	**Abdominal Discomfort**	**Dizziness**	**Other**

Is There Anything That You Think Which Is Important Pertaining To Your Complaint?

PLEASE CHECK ANY PAST OR CURRENT HEALTH PROBLEMS:

HEMPOHILIA		CANCER	
ANEMIA		UNDIAGNOSED LUMP	
FLACCID PARALYSIS		GOUT	
OSTEOARTHRITIS		OSTEOPOROSIS	
ANEURYSMS		ANKYLOSING SPONDYLITIS	
RHEUMATOID ARTHRITIS		MULTIPLE SCLEROSIS	
SYSTEMIC LUPUS ERYTHEMATOSIS		CHRONIC THROMBOSIS	
REITER'S SYNDROME		PHLEBITIS (SWOLLEN ARTERY)	
SCLERODERMA		SEVERE VARICOSE VEINS	
LOCAL IRRITABLE SKIN CONDITION		NEURITIS (SWOLLEN NERVE)	
HIV		EPILEPSY	
HEPATITIS		BRONCHITIS / EMPHYSEMA	
TUBERCULOSIS		ASTHMA	
HERNIA-INGUINAL OR ABDOMINAL		DIABETES	
PROLONGED CONSTIPATION		BUERGER'S DISEASE	
ENDOMETRIOSIS		CHRONIC KIDNEY DISEASE	
PELVIC INFLAMMATORY DISEASE		OSTEOPOROSIS	
ALCOHOL OR DRUG ADDICTION		IMMUNOLOGICAL DISEASE	
CHRONIC ABDOMINAL/DIGESTIVE DISEASE		FIBROMYALGIA	
POST CEREBROVASCULAR ACCIDENT (STROKE)		VASCULAR DISEASE	
POST MYOCARDIAL INFARCTION (HEART ATTACK)		RESPIRATORY DISEASE	
SEVERE HYPERTENSION (HIGH BLOOD PRESSURE)		ALLERGIC REACTIONS (ANAPHYLAXIS/SKIN)	
ATHEROSCLEROSIS (HARDENING OF THE ARTERIES)		ANY OTHER INFECTIOUS CONDITIONS	
VISION LOSS ANY OTHER DIAGNOSED DISEASES		LOW BLOOD PRESSURE INTERNAL PINS, WIRES, ARTIFICIAL JOINTS	

PLEASE CHECK IF YOU HAVE EVER EXPERIENCED ANY OF THE FOLLOWING, EVEN SHORT TEMPORARY EPISODES

BRUISE EASILY		HEARING LOSS IN ONE OR BOTH EARS	
FAINTING		DIFFICULTY SWALLOWING	
DIFFICULTY BREATHING/SHORTNESS OF BREATH		NUMBNESS IN ANY PART OF THE BODY	
CHRONIC COUGH		LOSS OF CONSCIOUSNESS	
SWOLLEN JOINTS PLEASE SPECIFY:			
DIZZINESS		SLURRED SPEECH	
CHEST PAIN		TEMPORARY LACK OF UNDERSTANDING	
RAPID HEART BEAT		WEAKNESS, CLUMSINESS OR LOSS OF STRENGTH IN THE FACE, FINGERS, HANDS, ARMS OR LEGS	
POOR CIRCULATION		SUDDEN COLLAPSE WITHOUT LOSS OF CONSCIOUSNESS	

ARE YOU PREGNANT? ○ **YES** ◉ **NO** **IF YES WHAT TRIMESTER?** _____

DO YOU HAVE ANY SURGICAL IMPLANTS SUCH AS PINS, NEEDLES, METAL PLATES, PACEMAKER, OTHER? IF YES WHERE? _____

_____

HOW WOULD YOU STATE YOUR PRESENT HEATH? _____

_____

WHAT IS YOUR CHIEF COMPLAINT? _____

I CERTIFY THAT THE INFORMATION GIVEN IN THIS FORM IS TRUE AND ACCURATELY REFLECTS MY PAST AND PRESENT HEALTH STATUS

_____ _____

PATIENTS SIGNATURE **DATE**