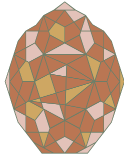


PINECONE WELLNESS

CONFIDENTIAL PATIENT HISTORY FORM

Name: ______________________ Gender: ______________________

Address: ______________________ City: ______________________

Province: ____________ Postal Code: ____________ Home: ______________________

E-mail: ______________________ Cell #: ______________________

Birth Date: ________(m) ________(d) ________(y) Occupation: ______________________

Medical Doctor: ______________________ Doctor's Phone #: ______________________

How did you hear about us? ______________________ Insurance Available: Yes ☐ No ☐

Do you want to receive our e-newsletter for promos and clinic news: Yes ☐ No ☐

Please indicate the conditions you are experiencing or have experienced:

CARDIOVASCULAR:

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chronic Congestive Heart Failure
- ☐ Heart Attack
- ☐ Phlebitis / Varicose Veins
- ☐ Stroke / CVA
- ☐ Pacemaker or Similar Device
- ☐ Heart Disease
- ☐ Dizziness / Vertigo

Is there a family history of any of the above? Yes ☐ No ☐

RESPIRATORY:

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Shortness of Breath

Is there a family history of any of the above? Yes ☐ No ☐

MUSCLE / JOINT PAIN:

- ☐ Neck
- ☐ Back (lower)
- ☐ Back (mid)
- ☐ Back (upper)
- ☐ Shoulders
- ☐ Elbow
- ☐ Wrist / Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle / Foot
- ☐ Spine

HEAD AND NECK:

- ☐ History of Headaches
- ☐ History of Migraines
- ☐ Vision Problems
- ☐ Visions Loss
- ☐ Ear Problems
- ☐ Hearing Loss

SKIN CONDITIONS:

- ☐ Eczema
- ☐ Psoriasis
- ☐ Rash
- ☐ Warts
- ☐ Open Sores

INFECTIOUS CONDITIONS:

- ☐ Skin Conditions: ______________________
- ☐ Respiratory Conditions: ______________________
- ☐ HIV / AIDS
- ☐ Hepatitis
- ☐ Other Infectious Disease: ______________________

DIGESTIVE:

- ☐ Constipation
- ☐ Crohns Disease
- ☐ Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Ulcers

WOMEN:

- ☐ Pregnancy

Due Date: ______________________

- ☐ Previous Pregnancy Complications: ______________________
- ☐ Menopausal Problems: ______________________
- ☐ Menstrual Problems: ______________________
- ☐ Gynecological Conditions: ______________________

MEN:

- ☐ Enlarged Prostate
- ☐ Libido Issues
- ☐ Other: ______________________

OTHER:

- ☐ Loss of sensation

Where? ______________________

- ☐ Diabetes

Onset: ______________________

Type: ______________________

- ☐ Allergies / Hypersensitivity

____

____

- ☐ Cancer

Type / Location: ______________________

- ☐ Arthritis

Is there a family history of arthritis? Yes ☐ No ☐

- ☐ Epilepsy
- ☐ Hemophilia
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Scoliosis
- ☐ Polio / Post Polio
- ☐ Osteoporosis

Do you have any medical conditions not listed above?: Yes ☐ No ☐

If yes, please describe: ______________________________

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of?

Yes ☐ No ☐ ______________________________

For what condition or reason are you seeking treatment today? ______________________________

____

Have you ever seen any other healthcare professional(s) for this condition or reason? Yes ☐ No ☐

If yes, whom: ______________________________

Have you ever been involved in any motor vehicle accidents? Yes ☐ No ☐ Date: ____________

Have you ever been involved in any other accidents? Yes ☐ No ☐ Date: ____________

Have you ever been knocked unconscious or suffered a concussion? Yes ☐ No ☐ Date: ____________

Briefly list any surgeries you have undergone, for what and when.

____

____

____

Are you presently taking any prescribed medications(s)? Yes ☐ No ☐

If yes, please list the medication(s) and the condition(s) for which it is being used.

____

____

Have you previously received other treatments?

____

Please circle on the following scales the extent to which you are currently satisfied with the following:

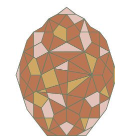
1 = little or no satisfaction *5 = total satisfaction*

Physical Health & Fitness	1	2	3	4	5
Mental and Emotional Happiness	1	2	3	4	5
Energy Level	1	2	3	4	5
Diet	1	2	3	4	5
Ability to Relax	1	2	3	4	5

I acknowledge that **Pinecone Wellness** Therapists are not Physicians and do not diagnose illness or disease or any other physical or mental disorder. I clearly understand that the treatments I receive at **Pinecone Wellness** are not a substitute for medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing.
I acknowledge that no assurance or guarantee has been provided to me as to the results of treatment.

I acknowledge and understand that the Therapists must be made fully aware of my existing medical conditions. I have completed my medical history form as provided by **Pinecone Wellness** and disclosed all medical conditions affecting me. It is my responsibility to keep **Pinecone Wellness** updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I acknowledge that I have been made aware that **Pinecone Wellness** has a Cancellation Policy of 24 hours notice prior to any appointment. If less than 24 hours notice is given a cancellation fee of 50% of the appointment cost will be applied.
I understand that I am liable for any costs my late cancellation incurs.



______________________________ ____________________

SIGNATURE DATE