raynen therapies

Health History Form

The information request below will assist us in treating you safely. Feel free to ask any question about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release information.

Name:_____ Phone #:_____

Address:_____

Occupation:_____ Date of Birth:_____

Have you had treatment for this condition before? ☐ Yes ☐ No

Did a health care practitioner refer you for treatment? ☐ Yes ☐ No Name: _____

Address: _____ Phone: _____

Family physician (if different from above): _____ Phone: _____

Address: _____

Please indicate conditions you are experiencing or have experienced.

Cardiovascular

☐ High blood pressure ☐ Phlebitis/varicose veins ☐ Stroke /CVA ☐ Heart attack
☐ Low blood pressure ☐ Blood clots ☐ Colds hands/feet
☐ Chronic congestive heart failure ☐ Cardiovascular accident ☐ Lymphedema

Respiratory

☐ Asthma ☐ Bronchitis ☐ Chronic cough ☐ Emphysema ☐ Shortness of breath

Head & Neck

☐ Ear problems ☐ Headaches ☐ Hearing loss ☐ Jaw pain (TMJD) ☐ Migraines
☐ Sinus problems ☐ Vision loss ☐ Vision Problems

Infectious Conditions

☐ Athlete's foot ☐ Hepatitis ☐ Herpes ☐ HIV ☐ Respiratory conditions ☐ Skin condition

Women

☐ Gynaecological conditions, what ?_____
☐ Pregnancy due date:_____

Soft tissue /joint dysfunction

☐ Ankles (L / R) ☐ Arms (L / R) ☐ Feet (L / R) ☐ Hands (L / R) ☐ Hips (L / R)
☐ Knees (L / R) ☐ Legs (L / R) ☐ Lower back (L / R) ☐ Mid back (L / R) ☐ Neck (L / R)
☐ Shoulder (L / R) ☐ Upper back (L / R)

Miscellaneous

☐ Allergies ☐ Anaphylaxis ☐ Arthritis ☐ Artificial joints ☐ Cancer ☐ Crohn's disease
☐ Diabetes ☐ Digestive conditions ☐ Dizziness ☐ Epilepsy ☐ Fibromyalgia ☐ Gout
☐ Haemophilia ☐ Insomnia ☐ Loss of sensation ☐ Lupus ☐ Osteoarthritis ☐ Osteoporosis
☐ Rheumatoid arthritis ☐ Shingles ☐ Stress ☐ Surgical pins or wire ☐ Other diagnosed disease

Neurological

☐ Burning ☐ Cerebral palsy ☐ Herniated disc ☐ Multiple sclerosis
☐ Numbness ☐ Parkinsons ☐ Stabbing ☐ Tingling

Current medications: _____

_____ Date: _____
Signature of patient