INFINITY HEALTH CENTRE

HEALTH HISTORY

What is your primary complaint?	Rate your pain (1-10)

When did you first notice symptoms? Cause?

Describe your current symptoms.

What activities or movements aggravate your condition?

What activities or movements relieve your condition?

Are your symptoms getting worse?	Does your condition interfere with:
□ Yes □ No	□ Work □ Sports □ Daily Life □ Sleep

Has there been a previous diagnosis?	Most recent full physical medical assessment:	
	□ 0 - 6 months ago	□ 7 - 12 months ago
	□ 1 - 2 years ago	□ Over 2 years ago

Have you had any of the following medical imaging?

□ X-Ray	Date:	Findings:
□ Diagnostic Ultrasound	Date:	Findings:
□ CT Scan	Date:	Findings:
□ MRI	Date:	Findings:
□ Other	Date:	Findings:

Please list any medications you are currently taking:

Med #1:	Reason:
Med #2:	Reason:
Med #3:	Reason:

Please list any previous surgeries, hospitalizations, or accidents:

Occupation	Occupational Duties

Family History

□ Cancer □ Heart Disease □ Hypertension

□ Diabetes □ Stroke □ Other:

PRACTITIONER NOTES

Please check any of the following conditions that you currently or have previously experienced

Musculo-Skeletal
- □ Headaches
- □ Neck Pain
- □ Low Back Pain
- □ Hip Pain
- □ Knee Pain
- □ Ankle/Foot Pain
- □ Shoulder Pain
- □ Wrist/Hand Pain
- □ Mid-Back Pain
- □ Jaw Pain/TMJ
- □ Bone Fracture
- □ Osteoporosis
- □ Osteopenia
- □ Scoliosis

Nervous System
- □ Numbness & Tingling
- □ Facial Twitching
- □ Chronic Fatigue
- □ Chronic Pain
- □ Sleeping Difficulty
- □ Paralysis
- □ Epilepsy
- □ Multiple Sclerosis
- □ Muscular Dystrophy
- □ Parkinson's Disease
- □ Spinal Cord Injury

Circulatory/Respiratory
- □ Dizziness
- □ Shortness of Breath
- □ Fainting
- □ Cold Feet/Hands
- □ Swollen Ankles
- □ Varicose Veins
- □ Blood Clots
- □ Previous Stroke
- □ Chest Pain
- □ Heart Disease
- □ High Blood Pressure
- □ High Cholesterol
- □ Low Blood Pressure
- □ Allergies
- □ Asthma
- □ Sinus Problems
- □ Lymphedema

Digestive
- □ Ulcers
- □ Indigestion
- □ Constipation
- □ Intestinal Gas/Bloating
- □ Diarrhea
- □ Irritable Bowel Syndrome
- □ Crohn's Disease
- □ Ulcerative Colitis

Skin
- □ Rashes
- □ Allergies
- □ Athlete's Foot
- □ Warts/Plantar Warts

Reproductive
- □ Currently Pregnant
- □ PMS
- □ Pre-Menopausal/Menopausal
- □ Pelvic inflammatory Disease
- □ Endometriosis
- □ Hysterectomy
- □ Infertility
- □ Prostate Problems
- □ Sexually Transmitted Disease
- □ Urinary Tract infection
- □ Bladder Infection
- □ Burning Upon Urination

Other
- □ Loss of Appetite
- □ Confusion/Forgetfulness
- □ Depression/Depressive Mood
- □ Difficulty Concentrating
- □ Hearing Impairment
- □ Visual Impairment
- □ Fibromyalgia
- □ Post-Polio Syndrome
- □ Infectious Diseases
- □ Congenital/Acquired Disabilities

Lifestyle
- □ Recreational Drug Use
- □ Alcohol Use
- □ Nicotine Use
- □ Caffeine Use

Print Name	Signature	Date
		YYYY | MM | DD

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