Health History Form

The information requested below will enable us to treat you safely. If you have any questions about the information requested please ask your health care professional. All information provided will be kept confidential within your Lifemark treatment team.

Chosen / Preferred Name
Last First

Legal Name
Last Middle initial First

Sex as assigned at birth
☐ Female ☐ Male ☐ Intersex ☐ Choose not to disclose

Current Gender Identity:
☐ Female ☐ Male ☐ Non-binary ☐ Two-Spirit
☐ Identity Not Listed (e.g.: genderqueer, gender fluid)
Please describe: _____
☐ Choose not to disclose

What are your Pronouns?
☐She/Her ☐He/Him ☐They/Them
☐ Not listed *please describe*: _____
☐ Choose not to disclose

Occupation:
_____

Have you received therapy before?
☐Yes ☐No *If yes:* What for and when?
_____
_____

What is your current reason for seeking therapy?
_____
_____

Please indicate conditions / injuries you have experienced or are currently experiencing:

Cardiovascular
(Past / Current)
☐ ☐ High blood pressure
☐ ☐ Low blood Pressure
☐ ☐ Heart attack
☐ ☐ Stroke/CVA
☐ ☐ Pacemaker, internal
☐ ☐ Defibrillator or similar device
☐ ☐ Heart disease

Skin
☐ ☐ Skin condition
☐ ☐ Open wound
☐ ☐ Loss of sensation *hot / cold*

Life Habits
☐ ☐ Alcohol
☐ ☐ Tobacco
☐ ☐ Cannabis
☐ ☐ Other Drugs

Do you have any metal implants (Pins, plates, joint replacements, artificial limbs)?
☐Yes ☐No

Musculoskeletal
Please circle Left / Right as appropriate
(Past / Current)
☐ ☐ Pain / Stiffness
☐ ☐ Weakness
☐ ☐ Osteoarthritis
☐ ☐ Rheumatological/inflammatory disease/autoimmune disorder (Rheumatoid Arthritis, lupus, other) (ie not OA)
☐ ☐ Osteoporosis
☐ ☐ TMJ pain/disorder
☐ ☐ Neck
☐ ☐ Upper back
☐ ☐ Mid back
☐ ☐ Lower back
☐ ☐ Hip *Left / Right*
☐ ☐ Knee *Left / Right*
☐ ☐ Ankle *Left / Right*
☐ ☐ Shoulder *Left / Right*
☐ ☐ Elbow *Left / Right*
☐ ☐ Wrist *Left / Right*
☐ ☐ Hand *Left / Right*
Other:

Other
(Past / Current)
☐ ☐ Cancer *(Type):*
_____
☐ ☐ Diabetes *(Type & Onset):*
_____
☐ ☐ Nervous system disorder:
_____
☐ ☐ Allergies:
_____
☐ ☐ An infectious disease *(Type):*
_____
☐ ☐ Thyroid disorder
☐ ☐ Epilepsy
☐ ☐ Hemophilia
☐ ☐ Mental Health Condition
☐ ☐ Sleep disorders
☐ ☐ Unexplained weight change
☐ ☐ Night fever / sweats
☐ ☐ Asthma
☐ ☐ Bowel or bladder changes

Are you or could you be pregnant?
(Due Date):
_____
Other:

Medications (prescribed or not)		
Type:	*Dosage / Prescribing Doctor:*	*Condition / Reason:*
Previous Surgeries		
Type:	*Date:*	*Condition / Reason:*
Are you currently seeing any other Health Care Professional?		
Designation (e.g. Chiropractor, Naturopath)	*Name*	*Condition / Reason:*
Any other information you would like us to know?		

Signed

Date *Day / Month / Year*

INTERNAL USE ONLY
Date of initial Health History:
Update 1:
Update 2:
Update 3: