**Personal Health History**

**Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The following form is to be completed prior to your consultation and emailed to the above contact details. Upon receiving the questionnaire, we will contact you via email to schedule your first consultation. Please complete the health history questionnaire. If you have any test results, etc. please feel free to attach copies along with any pertinent information not covered here. All information will be kept strictly confidential. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

**O = Occasional F = Frequent C = Constant**

**O F C**

**Muscle / Joint**

🞎 🞎 🞎 Arthritis

🞎 🞎 🞎 Bursitis

🞎 🞎 🞎 Foot trouble

🞎 🞎 🞎 Hernia

🞎 🞎 🞎 Low back pain

🞎 🞎 🞎 Lumbago

🞎 🞎 🞎 Neck pain, stiffness

🞎 🞎 🞎 Pain between shoulders

**General**

🞎 🞎 🞎 Allergy

🞎 🞎 🞎 Chills

🞎 🞎 🞎 Convulsions

🞎 🞎 🞎 Dizziness

🞎 🞎 🞎 Fainting

🞎 🞎 🞎 Fatigue

🞎 🞎 🞎 Fever

🞎 🞎 🞎 Headache

🞎 🞎 🞎 Loss of sleep

🞎 🞎 🞎 Loss of weight

🞎 🞎 🞎 Nervousness, depression

🞎 🞎 🞎 Neuralgia

🞎 🞎 🞎 Numbness

🞎 🞎 🞎 Sweats

🞎 🞎 🞎 Tremors

**O F C**

**Skin**

🞎 🞎 🞎 Boils

🞎 🞎 🞎 Bruise easily

🞎 🞎 🞎 Dryness

🞎 🞎 🞎 Hives or allergy

🞎 🞎 🞎 Itching

🞎 🞎 🞎 Skin eruptions (rash)

🞎 🞎 🞎 Varicose veins

**Pain or numbness in**

🞎 🞎 🞎 Shoulders

🞎 🞎 🞎 Arms

🞎 🞎 🞎 Elbows

🞎 🞎 🞎 Hand

🞎 🞎 🞎 Hips

🞎 🞎 🞎 Legs

🞎 🞎 🞎 Knees

🞎 🞎 🞎 Feet

🞎 🞎 🞎 Painful tailbone

🞎 🞎 🞎 Poor posture

🞎 🞎 🞎 Sciatica

🞎 🞎 🞎 Spinal curvature

🞎 🞎 🞎 Swollen joints

**O F C**

**Cardiovascular**

🞎 🞎 🞎 Hardening of arteries

🞎 🞎 🞎 High blood pressure

🞎 🞎 🞎 Low blood pressure

🞎 🞎 🞎 Pain over heart

🞎 🞎 🞎 Poor circulation

🞎 🞎 🞎 Rapid heartbeat

🞎 🞎 🞎 Slow heartbeat

🞎 🞎 🞎 Swelling of ankles

**Respiratory**

🞎 🞎 🞎 Chest pain

🞎 🞎 🞎 Chronic cough

🞎 🞎 🞎 Difficult breathing

🞎 🞎 🞎 Spitting up blood

🞎 🞎 🞎 Spitting up phlegm

🞎 🞎 🞎 Wheezing

Are you pregnant? 🞎Yes 🞎No

If yes, how many months?\_\_\_\_\_\_\_\_\_\_

**Describe your problem if scoliosis state the degree and type of curve:**

|  |
| --- |
| How long have you had this condition? Is it getting worse? 🞎 Yes 🞎 No |
| Does it bother your (check appropriate box): 🞎 Work 🞎 Sleep 🞎 Other (please specify) |
| What seemed to be the initial cause? |
| Are you under the care of a physician? 🞎 Yes 🞎 No If yes, for what reason? |
| Have you been hospitalized in the last 5 years? 🞎 Yes 🞎 No If yes, for major surgery? 🞎 Yes 🞎 No for serious injury? 🞎 Yes 🞎 No |
| Have you had any mental or emotional disorders? 🞎 Yes 🞎 No If yes, when? |
| Indicate the drugs do you now take? 🞎 Birth control pills 🞎 Tranquilizers 🞎 Pain Killers 🞎 Other (specify) |
| Do you wear: 🞎 heel lifts? 🞎 sole lifts? 🞎 inner soles? 🞎 area supports? 🞎 negative heels? 🞎 platform shoes? |
| How is most of your day spent? 🞎 standing 🞎 sitting 🞎 walking 🞎 other (specify) |

**Have you ever:** Yes No If yes, briefly explain.

- had a broken bone? 🞎 🞎

- been hospitalized? 🞎 🞎

- had strains or sprains? 🞎 🞎

- used a cane, crutch or other support? 🞎 🞎

- been struck unconscious? 🞎 🞎

- been hospitalized for other than surgery? 🞎 🞎

**Do you:**

- take minerals, herbs or vitamins? 🞎 🞎

- think you need minerals, herbs or vitamins? 🞎 🞎

- have any drug allergy? 🞎 🞎

**When did you last have:** Never 0-6 months. 6 -18 months. Longer

- spinal x-ray? 🞎 🞎 🞎 🞎

- spinal examination? 🞎 🞎 🞎 🞎

- physical examination? 🞎 🞎 🞎 🞎

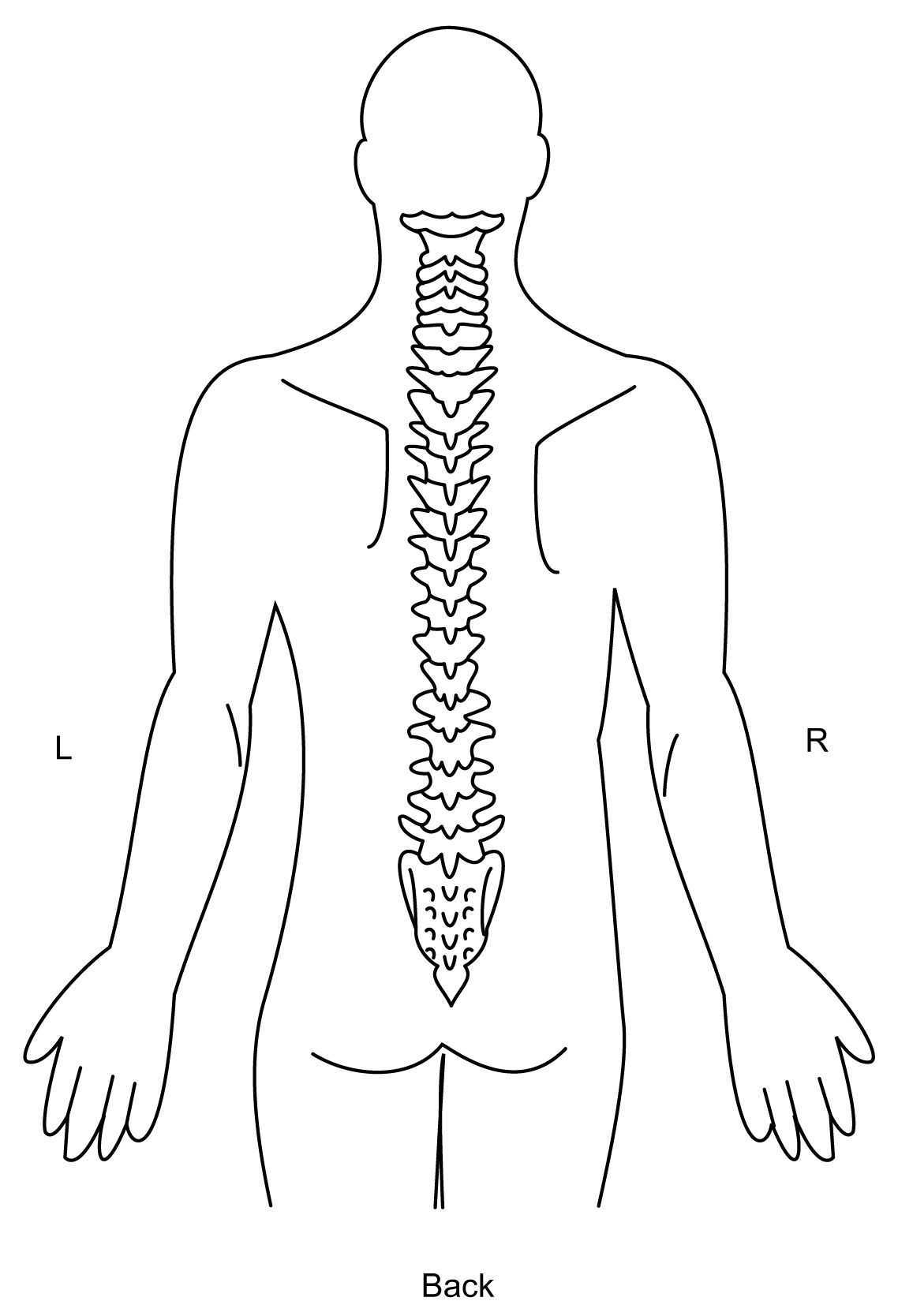
Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

**FAMILY HEALTH HISTORY:** Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

|  |  |
| --- | --- |
| RELATIONSHIP | PRESENT AND PAST HEALTH PROBLEMS |
|  |  |
|  |  |
|  |  |
|  |  |

**PATIENTS HEALTH HISTORY:** Information about your history living with scoliosis. Include information about when it was first diagnosed, how it has progress, symptoms related or unrelated to scoliosis, types and dates of treatment you have and anything else not discussed above which you would like to inform Dr. Kevin Lau.

Draw your scoliosis if possible.



Please mark your areas of pain on the figures below. 