mahaya
Health Services

2 College St. Suite 105
Toronto, ON M5G 1K3
info@mahayahealth.com
www.mahayahealth.com
T: 647.435.0152 F: 647.435.0163

OSTEOPATHIC PATIENT INFORMATION FORM

Name: ____

Address: ____

City: ________________________ Province: ___________ Postal Code: ___________

Phone: _______________________ Email: _____________________________________

☐ Male ☐ Female Other: _______________________

Date of Birth: ____________________ Blood Type: _______

Occupation: _________________________ Employed By: __________________________

Marital Status: ______________________ Number of children: ____________________

Emergency Contact: ___________________ Phone: ____________ Relation: _________

Name of Medical Doctor: _________________________________ Phone: ___________

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize us to do so.

Health Concerns

What are your main health concerns in order of importance to you?

____

Would you like to receive our newsletter? ☐ Yes ☐ No

Are you interested in information about our other healthcare practitioners? If so, which ones?

Naturopath RMT Yoga Holistic Nutritionist

How did you learn about Mahaya? ☐ Mahaya Website Booking

☐ Google ☐ Facebook ☐ Yelp ☐ Open Care ☐ Friend of Mahaya ☐ Other ___________

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Prescription Drugs

Are you taking any medication? **Y** ☐ **N** ☐

If yes, please indicate names and for how long you have been on this medication.

Family History

Please indicate if the family member suffered from any diseases

Relationship	**Diseases Suffered/ Cause of Death**
Grandfathers	
Grandmothers	
Father	
Mother	

Medical History

List any surgery or injury or cosmetic procedure and when it happened?

____

____

Are you seeing any other Health Care Providers for any type of treatments? **Y** ☐ **N** ☐

If yes, what are the treatments?

____

____

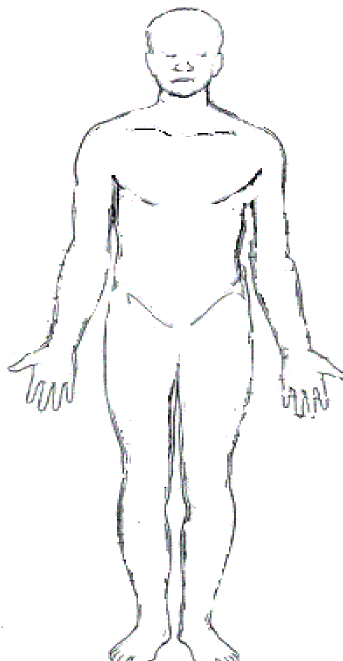
Have you heard about osteopathy before? **Y** ☐ **N** ☐

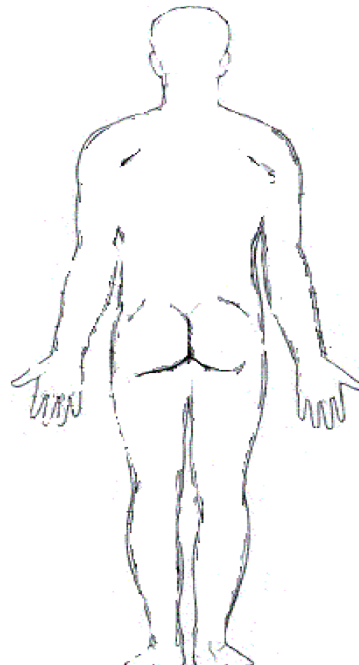
Have you ever received osteopathic treatment before? **Y** ☐ **N** ☐

Pain Diagram

On the following diagrams, indicate all areas of:

Pain – xxxx Stiffness - //// Numbness - 0000





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Medical History

In the lists below, check all major illnesses that you have experienced.

PAST MEDICAL HISTORY (please check all)	Chicken Pox	❐	Scarlet Fever	❐	Tonsillitis	❐
	Measles	❐	Pneumonia	❐	Ear infections	❐
	Mumps	❐	Frequent Colds	❐	High/Low Blood Pressure	❐
	Rubella	❐	Rheumatic Fever	❐	Hepatitis	❐
	Lung Disease	❐	Migraines	❐	AIDS/HIV	❐
	Diabetes	❐	Thyroid Disease	❐	Heart Disease	❐
	Liver Disease	❐	STI's	❐	Dermatitis	❐
	Kidney Disease	❐	Seizures	❐	Prolonged Bleeding	❐
	Cancer	❐	Stroke	❐	Arthritis	❐
	Asthma	❐	Menstrual Concerns	❐	Vision Concerns	❐
	Other:					

Please check "**√**" if you are experiencing the following symptoms or you have experienced these symptoms in the past.

General
- ❑ Poor/Change in appetite
- ❑ Cancer
- ❑ Diabetes
- ❑ Allergies
- ❑ Night sweats

Skin and Hair
- ❑ Eczema
- ❑ Loss of hair
- ❑ Thinning hair
- ❑ Dandruff

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Heart attack
- ❑ Phlebitis
- ❑ Stroke
- ❑ Cardiovascular accident
- ❑ Pacemaker or similar device
- ❑ Artificial valve
- ❑ Irregular heartbeat
- ❑ Dizziness

Respiratory
- ❑ Difficulty breathing
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Asthma

Gastrointestinal
- ❑ Indigestion
- ❑ Gas or burping
- ❑ Bad breath
- ❑ Constipation
- ❑ Diarrhea
- ❑ Abdominal pain or cramps
- ❑ Nausea
- ❑ Hemorrhoids
- ❑ Blood in stool
- ❑ Constant hunger
- ❑ Bloating

Neurological
- ❑ Loss of balance
- ❑ Irritable
- ❑ Poor memory

- ❑ Anxiety
- ❑ Depression
- ❑ Dizziness
- ❑ Lack of coordination
- ❑ Loss of sensation
- ❑ Emotional problems
- ❑ Other psychological problem

Genito-Urinary
- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Pain on urination
- ❑ Wake up at night to urinate
- ❑ Incontinence
- ❑ Kidney stones

Male
- ❑ Prostate problem
- ❑ Impotence
- ❑ Sores on genitals
- ❑ Ejaculation pain
- ❑ Infertility
- ❑ STI

Female
- ❑ Irregular periods
  - ❑ Heavy
  - ❑ Light
  - ❑ Clots
- ❑ Painful periods
- ❑ Vaginal discharge
- ❑ Infertility
- ❑ STI

Date of last Pap ________

Menopausal Y ❐ N ❐

Age of last menses ________

Pregnant Y ❐ N ❐

Do you practice birth control? Y ❐ N ❐

Type ____________________

Number of:

Pregnancies ___
abortions ___
miscarriages ___
births ___

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Diet: What is your diet like?

____

____

____

What is your weight? ________________ What is your weight goal? _______________

Diet: ☐ Non Vegetarian ☐ Vegetarian ☐ Vegan For how long? ________________

Physical Activity Readiness Questionnaire (PAR-Q)

Yes ❐ No ❐ 1. Has your doctor ever said you have heart trouble and that you should only do physical activity recommended by a doctor?

Yes ❐ No ❐ 2. Do you feel pain in your chest when you do physical exercise?

Yes ❐ No ❐ 3. In the past month, have you had chest pain when you were not doing physical activity?

Yes ❐ No ❐ 4. Do you lose your balance because of dizziness or do you ever lose consciousness?

Yes ❐ No ❐ 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?

Yes ❐ No ❐ 6. Is your doctor currently prescribing drugs (e.g. water pills) for your blood pressure or heart condition?

Yes ❐ No ❐ 7. Do you know of any other reason why you should not do physical activity?

SIGNATURE

I attest that the information provided is true and accurate to the best of my knowledge.

Signature: Date: ____________________
(DD/MM/YYYY)

Thank you for taking the time to fill out this questionnaire.
It will help greatly in my study of your present health concerns
and in my understanding of your health goals.
Your responses will assist me in choosing the appropriate treatment that will
bring about your return to optimal health.