Dmitro Jovnyruk - Manual Practitioner
Health History Form

Name: _____

Address: _____
Street Apt City Prov. Postal Code

DOB: _____ Phone – Home: _____ Phone – Work: _____

Occupation: _____ Referred by: _____ Email: _____

Chief/Main Complaint:

_____

History of Complaint:

_____

(Please circle all that apply) Do you have difficulty with any of the following?

Headaches	Dizziness	Earaches	Ringing in ears	Sinus problems
Loss of smell/Taste	Muscle & Joint Pain	Neck/Shoulder Pain	Back Pain (upper/Mid/Low)	TMJ/Jaw Pain
Swollen/Stiff Joint	Rheumatoid Arthritis	Osteoarthritis	Pins/needles in extremities	Cold Hands/Feet
Sensitive Skin/Rashes	Varicose Veins	Deep Vein Thrombosis	Eczema/Psoriasis	Chest pains
Heart disease	Hi/Lo Blood Pressure	Heart Palpitations	Poor Circulation	Stroke
Phlebitis	Poor Digestion	IBS	Constipation	Diarrhoea
Kidney/Bladder	Liver/Gallbladder	Chronic cough	Shortness of Breath	Asthma
Bronchitis/Emphysema	TB	Diabetes	Thyroid trouble	Cancer
HIV/AIDS	Hepatitis	Fatigue	Hormone Imbalance	Vision problems/Loss
Vertigo	Hearing loss	Sleep disorder	Memory loss	Anaemia

Other:_____

Women
Menstruation – Painful / Heavy / Light / Normal / Irregular / Absent / Pregnant
Number of Children: _____
Menopause – Pre / Active / Post
Breast Tissue – Swollen / Painful / Cystic / Abnormal sensation / Other

Allergies: _____

Previous Medical History - Incl. Trauma/Car Accidents:

_____

Surgical History (Type and Date):

_____

Family Medical History: (Cancer, Diabetes, Hi/Low Blood Pressure, Heart Disease, Other):

_____

Social History: Tobacco Coffee Drugs Alcohol Other

Any Special considerations: ▢ Pacemaker ▢ Rods ▢ Pins ▢ Wires ▢ Artificial joints/limbs ▢ Medication ▢Patch

▢Other _____