FALL RIVER
COLLABORATIVE HEALTH CARE

Osteopathy Health History Intake

Please describe the main concern(s) or symptoms bringing you in today and what you would like help with.

01. Reason(s) for seeking treatment:

_____

_____

02. Where are you experiencing symptoms?

Head ( ), Neck ( ), Jaw/TMJ ( ), Upper Back ( ), Mid Back ( ), Low Back ( ), Shoulder ( ), Elbow ( ), Wrist/Hand ( ), Hip ( ), Knee ( ), Ankle/Foot ( )

03. Onset

When did this concern begin?

Select an option:

Within the past few days ( ), Within the past week ( ), 2 - 4 weeks ( ), 1 - 3 months ( ),

3 - 6 months ( ), More than 6 months( ), More than 1 year ago ( ), Uncertain ( )

_____

04. Did the concern begin:

Select an option:

Suddenly ( ), Gradually ( ), After a specific incident or injury ( ), Other ( )

05. Duration/Pattern

How often do you experience this concern?

Constant ( ), Frequent (daily) ( ), Occasional ( ), Comes and Goes ( ),
Only with certain activities ( )

06. Local (No) or Radiating

Do your symptoms travel or spread to another area of your body? If **YES**, please describe **where:**

No ( ) Yes ( )

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07. Aggravating Factors

What tends to make your symptoms worse?

Sitting ( ), Standing ( ), Reaching, Lifting ( ), Household tasks ( ), Walking ( ), Exercise/Sport ( ),
Stress ( ), Poor Sleep ( ), Prolonged Posture ( ), None ( ), Other ( ) _____

08. Relieving Factors

What tends to make your symptoms better?

Rest ( ), Stretching ( ), Movement/Exercise ( ), Heat ( ), Ice ( ), Medication ( ),
Massage or Manual Therapy ( ), Other ( ) _____

09. Previous Treatment

Have you previously received treatment for this concern?

No Previous Treatment ( ), Osteopathy ( ), Physiotherapy ( ), Massage Therapy
Chiropractic ( ), Acupuncture ( ), Naturopathic Medicine ( ), Medical Care ( ),
Homeopathy ( ), Reflexology ( ), Reiki ( ), Other ( ) _____

10. Intensity

On average, how would you rate your discomfort?

0 - No Pain ( ), 1 - 3 - Mild ( ), 4 - 6 – Moderate ( ), 7 - 9 - Severe ( ), 10 - Worst imaginable Pain ( )

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11. Character

How would you describe your symptoms?

Sharp ( ), Dull ( ), Aching ( ), Stiff ( ), Burning ( ), Throbbing ( ), Tingling ( ), Numbness ( ), Pressure ( ), NA ( ) Other ( ) _____

12. Injuries / Trauma / Accidents

Have you experienced any significant injuries, accidents, physical trauma, or major emotional life events that you feel may have impacted your health? If **YES**, please list concern and the approximate date (if known):

No ( ) Yes ( )

13. Have you broken any bones? If **YES**, how many and the approximate date (if known):

No ( ) Yes ( )

---

14. Have you ever been knocked unconscious? If **YES**, how many and the approximate date (if known):

No ( ) Yes ( )

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15. Surgeries & Hospitalizations

Have you had any surgeries or been hospitalized in the past? If **YES**, please list the surgery or reason for hospitalization and the approximate date (if known):

No ( ) Yes ( )

_____

16. Do you have any artificial joints, internal pins/screws, wires, a pacemaker or other special equipment? If **YES**, please list:

No ( ) Yes ( )

_____

17. Diagnostic Imaging

Have you had any imaging or diagnostic tests related to your current concern or other health conditions? Please indicate the type of imaging, approximate date and what body area was scanned during the imaging:

No Imaging ( ) X-Ray ( ) MRI ( ) CT Scan ( ) Ultrasound ( ) Other ( )

18. Were you given a diagnosis based on this imaging

No ( ) Yes ( )

19. Mental Health / Emotional Well-Being

Anxiety ( ), Depression ( ), Panic attacks ( ), Chronic stress or burnout ( ),

Post-traumatic stress disorder ( ), Attention-deficit / ADHD ( ), Sleep disturbances / insomnia ( ), Mood disorder ( ), Eating disorder ( ), None / NA ( ), Other ( ) _____

20. Is there a family history of mental health conditions? If **YES**, please list:

No/Unsure ( ) Yes ( )

---

21. Stress

How would you rate your current stress level?

Low ( ) Moderate ( ) High ( )

22. Medication/Supplementation*

Are you currently taking any medications, supplements, or over-the-counter medications? If **YES**, please list them below:

No ( ) Yes ( )

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23. Allergies

Do you have any known allergies? If **YES**, please describe below:

No ( ) Yes ( )

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Activities of Daily Living & Lifestyle Questions

24. How would you rate your sleep quality most nights?

Select an option:

Very Good (wake feeling rested) ( )

Good/ Fair (occasionally disrupted) ( )

Poor (frequently disrupted or unrestful) ( )

25. Do you experience any of the following sleep concerns?

Difficulty falling asleep ( ), Difficulty staying asleep ( ), Waking frequently during the night ( ), Waking feeling unrested ( ), Pain that interferes with sleep ( ), None of the above ( ), Other ( ) _____

26. Do your symptoms affect your sleep?

No ( ) Yes ( )

27. Physical Activity Level

How would you describe your current activity level? Select an option:

Mostly Sedentary (Not Active) ( ), Lightly Active ( ), Moderately Active ( ), Very Active ( )

Do you participate in regular physical activity or exercise? If **yes**, please describe the type and how often you do it:

_____

28. Physical Activity / Exercise

No ( ) Yes ( )

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29. What hobbies or leisure activities do you regularly participate in?

Examples: crafts, knitting, painting, reading, musical instruments, gardening or similar activities.

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30. Work/Daily Demands

Does your work or daily routine involve any of the following:

Prolonged sitting ( ), Prolonged standing ( ), Repetitive movements ( ), Heavy lifting ( ), Physical labour ( ), Mostly varied movement ( )

31. Do you drink alcohol?

No ( ) Yes ( )

32. How many drinks per week?

0 1 2 3 4 5 6 7 +

33. Do you smoke? (including vape use)

No ( ) Yes ( )

34. How would you rate your smoking consumption?

Zero / Never ( ), Social Smoker ( ), Light Smoker ( ), Heavy Smoker ( ), Former Smoker ( )

35. Do you drink caffeine?

No ( ) Yes ( )

36. How many caffeine drinks per day?*

0 1 2 3 4 5 6 7 +

37. How would you rate your ability to relax and unwind?

1 - Very difficult to relax 5 - Sometimes able to relax, but it takes effort or doesn't last long
10 - Relax easily and regularly

0 1 2 3 4 5 6 7 8 9 10

Health Systems Review

Reviewing your health across different body systems helps us better understand how your body is functioning as a whole. Even symptoms that seem unrelated can provide important insight and help guide a more effective, individualized approach to your care.

Musculoskeletal System

38. Current or past symptoms/conditions (please select all that apply):*

Acute muscle and joint pain ( ), Chronic muscle and joint pain ( ), Swollen/stiff joints ( ),
Disc bulges or herniations ( ), Muscle weakness ( ), Back pain ( ), Jaw pain ( ),
Rheumatoid arthritis ( ), Osteoarthritis ( ), Ankylosing Spondylitis ( ), Spondylolisthesis ( ),
Tendonisis/Bursitis ( ), Scoliosis ( ), Bakers cyst ( ), None ( ), Unsure ( ),
Other ( ) _____

39. Is there a family history of any of the above conditions? If **YES**, please list:

No/Unsure ( ) Yes ( )

Nervous System

40. Current or past symptoms/conditions (please select all that apply):

Numbness/tingling sensation ( ), Paralysis ( ), Stroke or aneurism ( ), Balance loss ( ), Muscle weakness ( ), Epilepsy ( ), Fainting ( ), Multiple Sclerosis Fibromyalgia ( ), Parkinson's ( ), None ( ), Unsure ( ), Other ( ) _____

41. Is there a family history of any of the above conditions? If **YES**, please list.

No/Unsure ( ) Yes ( )

ENT (Ears, Nose and Throat)

42. Current or past symptoms/conditions (please select all that apply):

Dizziness/Vertigo ( ), Loss of vision ( ), Ear aches ( ), Tinnitus ( ), Hearing loss ( ), Sinus congestion ( ), Sinusitis ( ), Loss of smell ( ), Loss of taste ( ), Chronic laryngitis/pharyngitis/tonsilitis ( ), Difficulty swallowing ( ), Dental surgery (implants, crowns, recent extractions) ( ), Other ( ), None ( ), Unsure ( ), Other ( ) _____

43. Is there a family history of any of the above conditions? If **YES**, please list:

No/Unsure ( ) Yes ( )

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Cardiovascular System

44. Current or past symptoms/conditions (please select all that apply):

Chest pains ( ), Pain in left arm, shoulder, neck, up to the jaw ( ), Heart palpitations ( ),
Pacemaker ( ), Heart disease ( ), Heart attack ( ), High blood pressure ( ),
Low blood pressure ( ), Varicose veins ( ), Heart Attack ( ), Angina ( ), Aneurysm ( ),
Thrombosis ( ), Blood clots ( ), Raynauds ( ), Buerger's ( ), None ( ), Unsure ( ),
Other ( ) _____

45. Is there a family history of any of the above conditions? If YES, please list.

No/Unsure ( ) Yes ( )

Respiratory System

46. Current or past symptoms/conditions (please select all that apply):

Asthma ( ), Bronchitis ( ), Pneumonia ( ), Emphysema ( ), Chronic cough/cold/flu ( ),
Shortness of breath ( ), Sinusitis ( ), Sinus congestion ( ), Tuberculosis ( ),
None ( ), Unsure ( ), Other ( ) _____

47. Is there a family history of any of the above conditions? If YES, please list.

No/Unsure ( ) Yes ( )

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Digestive System (Upper AND Lower Digestion)

48. Current or past symptoms/conditions (please select all that apply):

Nausea ( ), Food sensitivities ( ), Loss/increase in appetite ( ), Recent or sudden weight gain or weight loss ( ), IBS Colitis ( ), Crohn's disease ( ), H. Pylori ( ), Gas/Bloating ( ), Acid reflux ( ), Ulcer(s) ( ), Hernia ( ), Gall stones ( ), Hepatitis ( ), Cirrhosis or fatty liver ( ), Hemorrhoids ( ), Constipation ( ), Diarrhea ( ), None ( ), Unsure ( ), Other ( ) _____

49. Is there a family history of any of the above conditions? If YES, please list.

No/Unsure ( ) Yes ( )

---

50. Bowel Movement Frequency

How often do you typically have a bowel movement?

Select an option:

More than once per day ( ), Once per day ( ), Every 2 - 3 days ( ), Less than every 3 days ( ), Irregular/Varies ( )

51. Quality/Completeness (select all that apply)

How would you describe your bowel movements?

Regular and comfortable ( ), Hard or difficult to pass ( ), Loose or watery ( ), Irregular in shape or consistency ( ), Feeling of incomplete evacuation ( ), Occasional constipation ( ), Occasional diarrhea ( )

52. Have you noticed recent changes in your bowel habits?

No ( ) Yes ( )

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Urinary System

53. Current or past symptoms/conditions (please select all that apply):
Painful or burning urination ( ), Urgency ( ), Incontinence ( ), Bladder prolapse ( ),
Kidney stones ( ), Kidney failure ( ), Chronic urinary tract infections (UTIs) ( ),
Chronic yeast infections ( ), Difficulty starting urination ( ), Incomplete bladder emptying ( ),
Cancer ( ), Other ( ), None ( ), Unsure ( ), Other ( ) _____

54. Is there a family history of any of the above conditions? If YES, please list.

No/Unsure ( ) Yes ( )

---

55. Do you wake during the night to urinate? If **YES**, how many times per night:

No ( ) Yes ( )

Reproductive System (Ovarian/Uterine History)

*The following questions relate to women's health. If they do not apply to you, please skip ahead to Question **67.***

56. Current or past symptoms/conditions (please select all that apply):

None/Not Applicable ( ), Painful periods (dysmenorrhea) ( ), Irregular menstrual cycles ( ),
Heavy menstrual bleeding ( ), Absent periods ( ), Premenstrual syndrome (PMS) ( ),
Leucorrhoea ( ), Endometriosis ( ), PCOS ( ), Ovarian cysts ( ), Uterine fibroids
Uterine prolapse ( ), Pelvic Pain ( ), Pain with intercourse ( ), Infertility or difficulty conceiving ( ),
Perimenopause concerns ( ), Menopause ( ), Cancer ( ), Unsure ( )

Other ( ) _____

57. Is there a family history of any of the above conditions? If **YES**, please list:

No/Unsure ( ) Yes ( )

Menstruation History

58. Are your menstrual cycles regular?

No/Unsure ( ) Yes ( )

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59. On average, how many days is your cycle?

0 1 2 3 4 5 6 7 +

60. Age of first menstruation

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61. Please check any symptoms your experience before, during, or after your period.

None ( ), Cramps ( ), Bloating ( ), Fatigue ( ), Headaches ( ), Migraines ( ), Breast Tenderness ( ), Acne/Breakouts ( ), Diarrhea ( ), Constipation ( ), Lower back pain ( ), Lower abdominal pain ( ), Muscle or joint pain ( ), Decreased appetite ( ), Increased appetite ( ), Mood changes ( ), Anxiety ( ), Depressed mood ( ), Sleep disturbances ( ),
Other ( ) _____

62. If you are post-menopausal, how old were you when your periods stopped?

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Pregnancy History

63. Are you currently:

Not Pregnant ( ), Pregnant ( ), Trying to conceive ( ), Postpartum (within the past 12 months) ( )

64. Have you ever been pregnant? If **YES**, how many pregnancies?

No ( ) Yes ( )

---

65. If applicable, please indicate delivery type:

Vaginal delivery ( ), Cesarean section (c-section) ( ), Assisted delivery (forceps/vacuum) ( )

66. Any pregnancy or birth complications? If **YES**, please describe.

No ( ) Yes ( )

Reproductive System (Testes/Prostate History)

The following section includes questions related to men's health. If this section does not apply to you, please skip ahead to Question 69.

67. Current or past symptoms/conditions (please select all that apply):

None/Not Applicable ( ), Erectile dysfunction ( ), Decreased libido ( ), Prostate enlargement ( ), Prostate infection (prostatitis) ( ), Prostate cancer ( ), Testicular pain ( ), Testicular swelling or lumps ( ), History of testicular injury ( ), Infertility or difficulty conceiving ( ), Vasectomy ( ), Cancer ( ), Unsure ( )

Other ( ) _____

68. Is there a family history of any of the above conditions? If **YES**, please list.

No/Unsure ( ) Yes ( )

Immune/Lymphatic System

69. Current or past symptoms/conditions (please select all that apply):

Frequent colds and/or flus ( ), Chronic fatigue ( ), Edema/Swelling ( ), Swollen lymph nodes ( ), Lymphedema ( ), Slow wound healing ( ), Autoimmune disorder ( ), Immunodeficiency disorder ( ), Allergies (environmental) ( ), History of mononucleosis (mono) ( ), Lymphoma ( ), Lyme Disease ( ), None ( ), Unsure ( ), Other ( ) _____

70. Is there a family history of any of the above conditions? If **YES**, please list.

No/Unsure ( ) Yes ( )

Integumentary System (Skin)

71. Current or past symptoms/conditions (please select all that apply):

Sensitive skin/rashes ( ), Dry skin ( ), Acne ( ), Eczema ( ), Psoriasis ( ), Open sores
Warts ( ), Athletes foot ( ), Herpes ( ), Cancer ( ), None ( ), Unsure ( ),

Other ( ), _____

72. Is there a family history of any of the above conditions? If **YES**, please list.

No/Unsure ( ) Yes ( )

Endocrine System

73. Current or past symptoms/conditions (please select all that apply):

Diabetes ( ), Insulin resistance ( ), Hypoglycemia (low blood sugar) ( ), Hypo Thyroid ( ),
Hyper Thyroid ( ), Goiter or thyroid nodules ( ), Hormone imbalance ( ), Addison's disease ( ),
Cushing syndrome ( ), Growth hormone disorders ( ), Pancreatic dysfunction ( ),
Pituitary gland dysfunction ( ), Pineal gland dysfunction ( ), None ( ), Unsure ( ),

Other ( ) _____

74. Is there a family history of any of the above conditions? If **YES**, please list.

No/Unsure ( ) Yes ( )

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75. Is there anything else about your health, symptoms, or experiences that you feel would be important for your practitioner to know?

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