

Health History Form

Name: _____ Phone #: _____

Address: _____ Postal Code: _____

Email: _____ Occupation: _____

Date of Birth: _____ Emergency contact: _____

How did you hear about our clinic? _____

Reason for visit: _____ Referred by: _____

Current medications: _____

Physician's Name: _____ Chiropractor: _____ Physiotherapist: _____

Please indicate if you experience or have experienced any of the following conditions:

CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- Heart disease
- Heart attack
- Stroke/CVA
- Pace maker
- Circulation problems

RESPIRATORY

- Chronic cough
- Shortness of breath
- Bronchitis
- Asthma
- Emphysema

INFECTIONS

- Hepatitis
- TB
- HIV
- Herpes
- Contagious disease

OTHER CONDITIONS

- Cancer
- Kidney Disease
- Diabetes
type: _____
onset: _____
- Epilepsy
- Arthritis
- Allergies: _____
- Skin Conditions
what: _____
- Osteoporosis
- Mental illness
- Hemophilia
- Other: _____

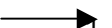
HEAD/NECK

- History of headaches
- History of migraines
- Sudden vision problems
- Sudden hearing problems
- Previous whiplash injury
when: _____

WOMEN

- Pregnant, due: _____
- Painful menstruation
- Menopause
- Breast exam
date: _____
results: _____
- Bone density exam
date: _____
results: _____

Please see over



Please draw the location of your pain or discomfort on the images below;

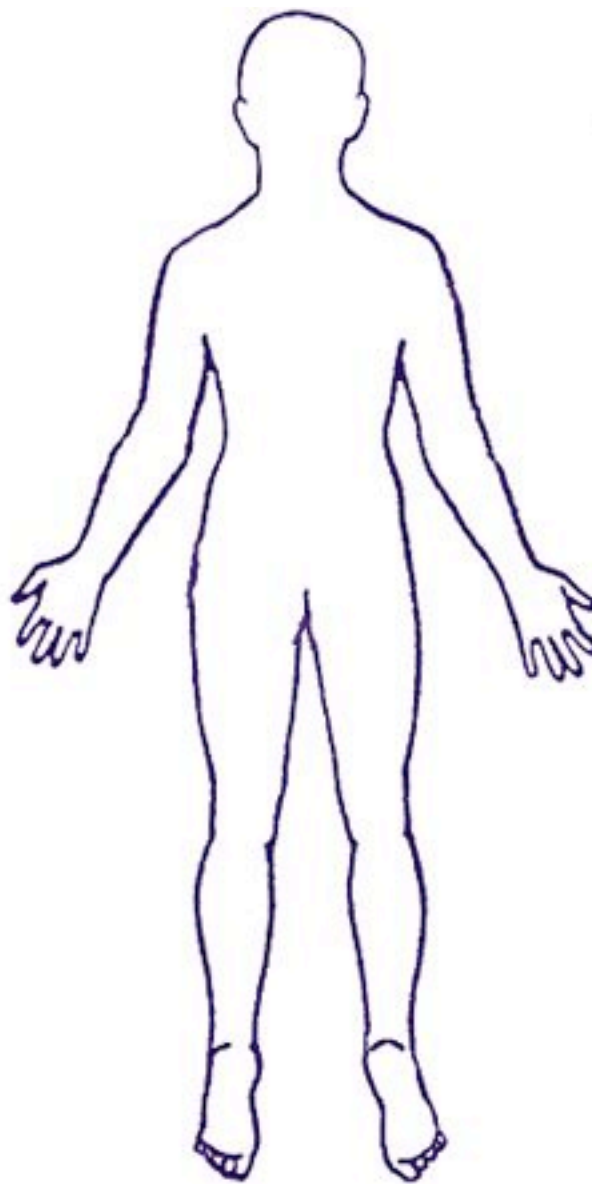
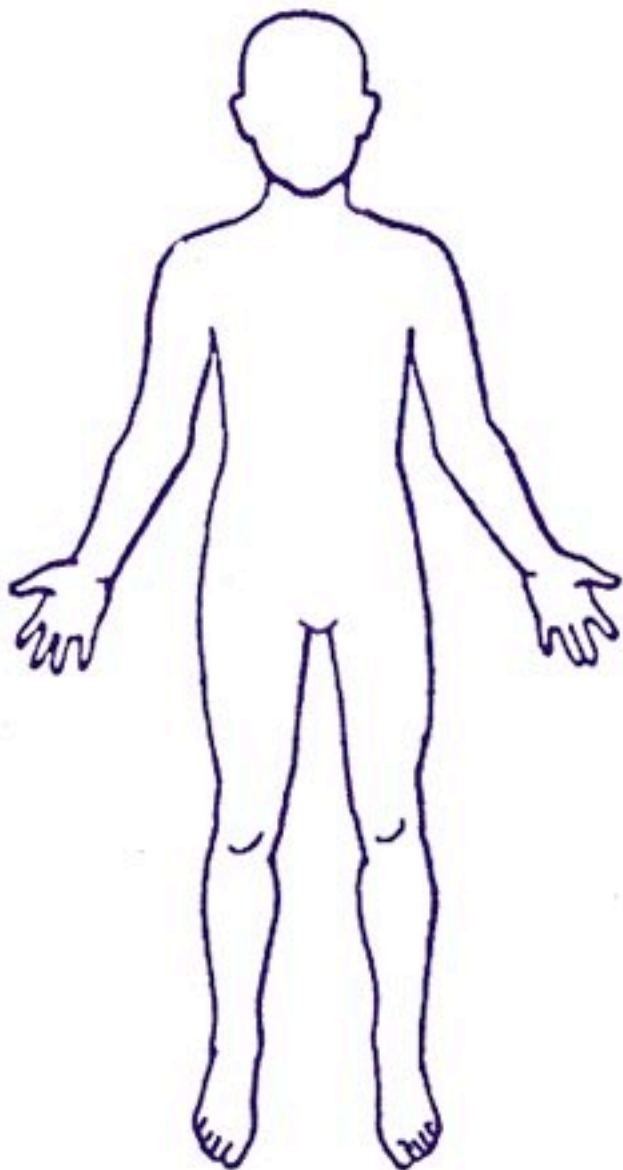
Indicate:

x = pain/discomfort

Z = tingling/numbness

o = loss of sensation

c = cramping



Patient signature: _____ Date: _____