

The information requested will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Street & # Apt # City/Prov Postal Code

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Health Card #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_ Relationship \_\_\_\_\_

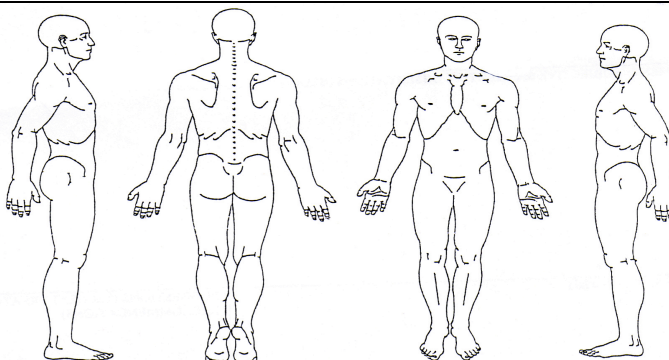
Blue Cross Coverage? If yes, Policy #: \_\_\_\_\_ ID# \_\_\_\_\_

Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Who can we thank for referring you to our clinic?: \_\_\_\_\_ Yellow Pages  yes  no

WCB claim: <input type="checkbox"/> yes <input type="checkbox"/> no Claim#: _____	Date of Accident: _____
Motor Vehicle Accident: <input type="checkbox"/> yes <input type="checkbox"/> no	Date of Accident: _____

Major complaint: \_\_\_\_\_

<p><b>KEY:</b></p> <p>Circle the area on your body where you have stiffness, muscle aches, pain, or discomfort.</p>	
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What makes the condition worse?: \_\_\_\_\_

What makes the condition better?: \_\_\_\_\_

Have you had this condition in the past?:  yes  no If yes, was it resolved?:  yes  no

Did you have x-rays for this condition?  yes  no If yes where on the body? \_\_\_\_\_

Are you seeing a chiropractor?:  yes  no  Dr. Fox  Dr. Peddle Other: \_\_\_\_\_

Stress Level:  none  slight  moderate  severe

Physical Activity:  none  low (1 or 2x per week)  moderate (3 – 4x per week)  high (5x + per week)

(more on the other side...)

## Client Health History Form

<p><b>Cardiovascular System</b></p> <input type="checkbox"/> aneurysm <input type="checkbox"/> high blood pressure/hypertension <input type="checkbox"/> low blood pressure/hypotension <input type="checkbox"/> heart disease <input type="checkbox"/> stroke <input type="checkbox"/> varicose veins <input type="checkbox"/> phlebitis <input type="checkbox"/> bruise easily <input type="checkbox"/> pacemaker	<p><b>Nervous System</b></p> <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> Parkinson's <input type="checkbox"/> seizures/epilepsy <input type="checkbox"/> carpal tunnel <input type="checkbox"/> altered/loss of sensation Specify areas: _____ _____	<p><b>Medications</b></p> <p>Please indicate type, what it is for and the times that it is taken:</p> _____ _____ _____ _____
<p><b>Digestive Systems</b></p> <input type="checkbox"/> ulcers <input type="checkbox"/> constipation <input type="checkbox"/> ulcerative colitis <input type="checkbox"/> Crohn's disease <input type="checkbox"/> gall stones <input type="checkbox"/> irritable bowel syndrome (IBS) <input type="checkbox"/> liver disease Other (specify): _____ _____	<p><b>Skin</b></p> <input type="checkbox"/> plantar warts <input type="checkbox"/> eczema <input type="checkbox"/> psoriasis <input type="checkbox"/> fungal infection (ex. athlete's foot) <input type="checkbox"/> herpes simplex Other (specify): _____ _____	<p><b>Respiratory Systems</b></p> <input type="checkbox"/> bronchitis <input type="checkbox"/> asthma <input type="checkbox"/> emphysema <input type="checkbox"/> sinusitis <input type="checkbox"/> chronic cough <input type="checkbox"/> breathing problems Specify: _____ _____
<p><b>Head/Neck</b></p> <input type="checkbox"/> history of headaches <input type="checkbox"/> history of migraines <input type="checkbox"/> vision problems or loss <input type="checkbox"/> hearing/ear problems <input type="checkbox"/> dizziness	<p><b>Other Conditions</b></p> <input type="checkbox"/> hepatitis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> diabetes <input type="checkbox"/> chronic fatigue syndrome <input type="checkbox"/> environmental illness <input type="checkbox"/> allergies Specify: _____ _____	<p><b>Muscles and Joints</b></p> <input type="checkbox"/> fibromyalgia <input type="checkbox"/> osteoporosis <input type="checkbox"/> arthritis Specify type and location: _____ _____ <input type="checkbox"/> pain/stiffness: <input type="checkbox"/> head <input type="checkbox"/> neck <input type="checkbox"/> jaw <input type="checkbox"/> back <input type="checkbox"/> Lower <input type="checkbox"/> Middle <input type="checkbox"/> Upper <input type="checkbox"/> arm/hand <input type="checkbox"/> leg/foot
<p><b>Women</b></p> <input type="checkbox"/> menopausal problems <input type="checkbox"/> painful menstruation <input type="checkbox"/> pregnant Due date: _____ _____ <input type="checkbox"/> caesarean section <input type="checkbox"/> endometriosis Other (specify): _____ _____	<input type="checkbox"/> tumours/cysts <input type="checkbox"/> cancer Specify: _____ _____ Other (specify): _____ _____	
<p><b>Other Healthcare</b></p> <input type="checkbox"/> physician/medical doctor <input type="checkbox"/> chiropractor <input type="checkbox"/> massage therapist <input type="checkbox"/> physiotherapist <input type="checkbox"/> naturopathic doctor <input type="checkbox"/> nutritionist/dietician Other (specify): _____ _____	<p><b>Surgeries</b></p> <p>Please indicate type, area(s) and date of surgery:</p> _____ _____ _____ _____	<p><b>Previous Injuries</b></p> <p>Please indicate area(s), date of injury and a brief description of what happened:</p> _____ _____ _____ _____

By my signature below, I authorize that all of the information is filled to the best of my knowledge. I understand that all my personal information is confidential and will be treated in accordance with the Personal Information Act.  
**Please allow 24 hours notice for cancellation of appointments. There will be a \$25 fee for any appointments missed without sufficient notice.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_