

Name \_\_\_\_\_ Birth date (DD/MM/YYYY) \_\_\_\_\_

Street Address \_\_\_\_\_ City of \_\_\_\_\_ Postal Code \_\_\_\_\_

Home ☎ \_\_\_\_\_ Work ☎ \_\_\_\_\_ E-Mail \_\_\_\_\_

Your Occupation \_\_\_\_\_ Who Referred You? \_\_\_\_\_

Physician Name / Address \_\_\_\_\_ Extended Health Care?  Yes  No

Symptoms? \_\_\_\_\_

**Please describe your symptoms:**

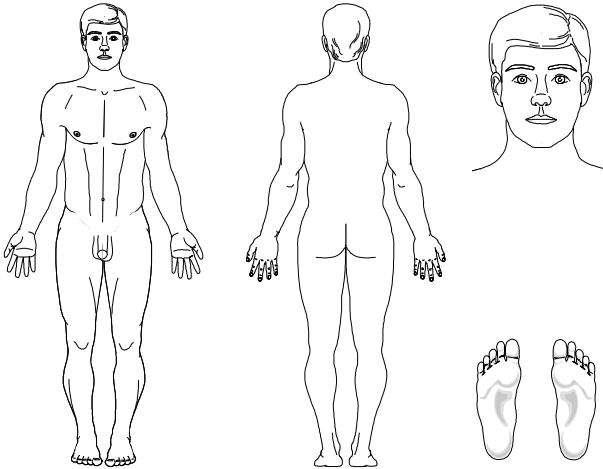
*Sensation:*  sharp  dull  achey  throbbing  
 burning  "numb" or pins and needles  other

*Frequency:*  rarely experience  comes & goes  
 frequent  constant

*What is the intensity of this discomfort?*  
 0 1 2 3 4 5 6 7 8 9 10  
 No pain Intolerable

*This discomfort is affecting your:*  
 work  activity / sports  home life  sleep

Please mark areas of:  symptoms  no symptoms



**Health History**  current conditions  experienced in the past

<p><b>Muscle, Skeletal and Nervous Systems</b></p> <input type="checkbox"/> tension or migraine headaches <input type="checkbox"/> whiplash / motor vehicle accident <input type="checkbox"/> neck or shoulder pain or stiffness <input type="checkbox"/> back or hip pain or stiffness <input type="checkbox"/> upper extremity weakness or tingling <input type="checkbox"/> lower extremity weakness or tingling <input type="checkbox"/> head trauma or concussion <input type="checkbox"/> loss of co-ordination or dizziness <input type="checkbox"/> sleep or personality changes <input type="checkbox"/> light-headedness / fatigue <input type="checkbox"/> epilepsy / seizures <input type="checkbox"/> TMJ or tooth, jaw or ear pain <input type="checkbox"/> vision or hearing difficulty or loss <input type="checkbox"/> degenerating discs <input type="checkbox"/> osteo or rheumatoid arthritis <input type="checkbox"/> osteoporosis or bone disease <input type="checkbox"/> spasm & strain or sprain <input type="checkbox"/> tendonitis, fibrositis or bursitis <input type="checkbox"/> fractures / pins, wires, plates <input type="checkbox"/> carpal tunnel syndrome <input type="checkbox"/> loss of sensation <p><b>Heart and Circulatory Systems</b></p> <input type="checkbox"/> high or low blood pressure <input type="checkbox"/> chronic congestive heart failure <input type="checkbox"/> heart disease / attack or stroke (CVA) <input type="checkbox"/> chest pain or angina <input type="checkbox"/> pacemaker or similiar device <input type="checkbox"/> varicose veins or phlebitis <input type="checkbox"/> cold hands & feet or swelling <input type="checkbox"/> diabetes <input type="checkbox"/> poor healing / bruise easily	<p><b>Skin and Immune Systems</b></p> <input type="checkbox"/> open sores, cuts or warts <input type="checkbox"/> contagious skin disease <input type="checkbox"/> tuberculosis or hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> cancer <input type="checkbox"/> allergies (food, environmental) <p><b>Breathing System</b></p> <input type="checkbox"/> asthma <input type="checkbox"/> bronchitis or emphysema <input type="checkbox"/> shortness of breath <input type="checkbox"/> frequent colds or sinus <input type="checkbox"/> chronic cough / smoking <p><b>Digestive System</b></p> <input type="checkbox"/> nausea or vomiting <input type="checkbox"/> constipation <input type="checkbox"/> rapid weight loss <input type="checkbox"/> appetite changes <input type="checkbox"/> diarrhea <input type="checkbox"/> bad taste in mouth <input type="checkbox"/> irritable bowel <input type="checkbox"/> ulcers <input type="checkbox"/> gall bladder problems <p><b>Genitourinary System</b></p> <input type="checkbox"/> painful urination <input type="checkbox"/> unusual colour / odour <input type="checkbox"/> hip or flank pain <input type="checkbox"/> gynecological concerns <input type="checkbox"/> pregnant currently <p><b>Life Questions</b></p> <input type="checkbox"/> I exercise regularly <input type="checkbox"/> I feel good about life <input type="checkbox"/> I have good sleeping patterns <input type="checkbox"/> I have poor energy levels <input type="checkbox"/> I suffer from too much stress
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Please rate your overall health  
 1 2 3 4 5 6 7 8 9 10  
 Poor Moderate Excellent

Prominent family illnesses \_\_\_\_\_

Current medications \_\_\_\_\_ Other treatment \_\_\_\_\_

Major injuries or surgeries \_\_\_\_\_ Year(s)? \_\_\_\_\_

Can we contact you by email?  Yes  No  Check here if you would prefer not to receive our clinic newsletter

*I understand that all information gathered for this treatment is confidential, except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. I understand I will be asked for written authorization for release of any information outside my circle of care. I have reviewed the fee schedule and cancellation policy, and I understand I must give at least 24 hours notice to reschedule my appointment. I will inform my therapist should anything change regarding my health status.*

Today's Date \_\_\_\_\_ Signature \_\_\_\_\_