PATIENT HISTORY FORM

Name: ____

Address: ______________________________________ Postal Code: ___________

Phone (h) _______________________ Phone (w) ___________________________

Date of Birth: ____________________ Occupation: _________________________

Hospitalization Number: _________________________

Family Physician: ______________________________

Phone #: _________________________

Has a physician treated you for:

Heart condition: ____________________

Hypertension: _______________________

TMJ: ______________________________

Respiratory: ________________________

Allergies: __________________________

Headaches: ____________________

Fainting/Dizziness: _______________

Cancer: ________________________

Skin Conditions: _________________

Stomach Ailments: _______________

Have you had any of the following? When?

Sprains/Strains: ____

Fractures: ____

Dislocations/subluxations: ____

Surgery: ____

In the last two years have you been treated by?

Medical Doctor: ______________________________

Chiropractor: ________________________________

Physiotherapist: ______________________________

Massage Therapist: ___________________________

Are you currently taking medications? Please list below.

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I, ________________________________ declare that the above information is true to the best of my knowledge.

Signed: _________________________________ Date: _________________