Health History Form

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

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **Postal Code:** _____

Phone: Home #: _____ **Work/Other #** _____

Email: _____ **Referred By:** _____

Occupation: _____ **Preferred Contact:** **Phone** **Mail** **Email**

Please indicate conditions you are/have experienced.

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Heart Disease
- ☐ Phlebitis
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Varicose veins

Is there family history of any of the above? Yes No

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

Is there family history of any of the above? Yes No

Infections
- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions

☐Loss of sensation/where _____

☐Diabetes, onset: _____

☐Allergies/hypersensitivity: _____

☐Epilepsy

☐Cancer, Where? _____

☐Skin conditions, what? _____

☐Arthritis: Type, Where? _____

Is there family history of arthritis? Yes No

Head/Neck
- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision Loss
- ☐ Ear problems
- ☐ Hearing Loss

Women

☐Pregnant, Due: _____

☐Gynaecological conditions, what? _____

Overall. How is your general health? _____

Primary Care Physician: _____

Address: _____

Phone #: _____

Current medications: _____

_____

Condition it treats: _____

_____

Are you receiving care from another health professional? (chiropractor, physiotherapist)

_____

Surgery- date: _____ Nature: _____

Injury-date: _____ Nature: _____

Any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) Yes No What? _____

_____

Any internal pins, wires, artificial points? Yes No What/Where? _____

_____