



Patient History Form:

Name:

Date:

Address:

City:

Tel # (home)

Date of Birth:

What is your primary complaint?

Postal Code:

Tel #: (cell)

Occupation:

Health History: Please indicate conditions you are experiencing or have experienced:

General Health Conditions

- Diabetes
- Menstrual cramps
- Epilepsy
- Cancer
- Arthritis
- Osteoporosis
- Varicose veins
- Eczema
- Asthma
- Allergies (please list)

Respiratory

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

Cardiovascular

- High blood pressure
- Low blood pressure
- CCHF
- Heart attack
- Phlebitis
- Stroke/ CVA
- Pacemaker or similar device

Give a brief description of areas that create discomfort.

Current Medications:

Chiropractor's name:

Referred by:

Signature: _____

Appointments cancelled with less than 24 hours notice will be billed \$35.00.