PATIENT HISTORY FORM

Name:_____ Date: _____

Address: _____ Birthday: _____

Postal Code: _____

Phone: H:_____ W:_____ C:_____

Email: _____

Occupation: _____

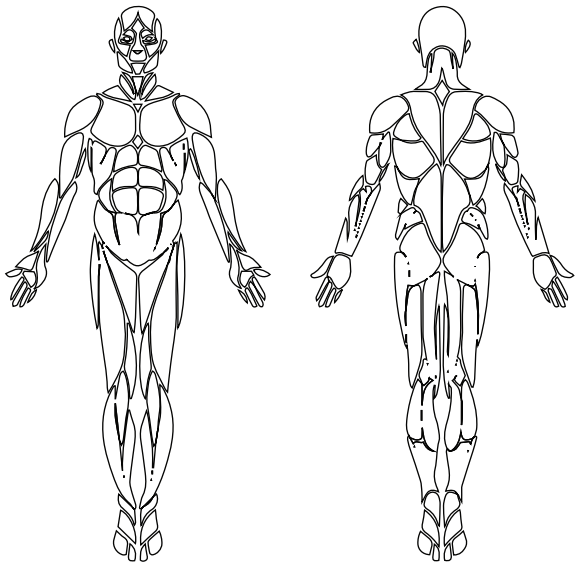
Physician: _____ Phone: _____

Address: _____

SGI ( ) Adjuster: _____ Claim #: _____

Whom may we thank for referring you to our clinic? _____

Please describe your present complaint and shade in areas of pain/discomfort on the diagram:



_____

_____

_____

_____

_____

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_____

_____

_____

Rate your pain 1 being no pain at all and 10 being the worst possible:

1… 2… 3… 4… 5… 6… 7… 8… 9… 10

List previous injuries, accidents, or surgeries with their dates or year:

_____

_____

_____

_____

Have you received treatments from any of the following providers?

[ ] Physician [ ] Chiropractor [ ] Physiotherapist [ ] Massage Therapist [ ] Acupuncturist

Name of Provider: _____ Name of Provider: _____

Reason for treatment: _____ Reason for treatment: _____

Results: _____ Results: _____

PATIENT HISTORY FORM

Have you been diagnosed or treated by a physician for any of the following medical conditions?

- ☐ Allergies ☐ High ☐ Low Blood Pressure ☐ Respiratory Conditions
- ☐ Arthritis ☐ Heart Conditions ☐ Neurological Conditions
- ☐ Cancer ☐ TMJ ☐ Whiplash
- ☐ Cholesterol ☐ Headaches ☐ Skin Conditions
- ☐ Diabetes ☐ HIV ☐ Varicose Veins
- ☐ Digestive Disorders ☐ Hepatitis
- ☐ other: _____

Does your immediate family have any of the following conditions?

- ☐ Back Pain ☐ High ☐ Low Blood pressure ☐ Cancer
- ☐ Heart Disorders ☐ Arm/Shoulder Pain ☐ Respiratory Conditions
- ☐ Headaches ☐ Arthritis ☐ Neurological Conditions
- ☐ Digestive Disorders ☐ Diabetes

Are you presently taking any prescription medication?
List the Name(s), Reason(s) and Duration:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you presently taking any non-prescription medication?
☐ No ☐ Yes If yes, list:_____

The information contained on this form is true and complete to the best of my knowledge.

_____ _____
Signature of Patient/Guardian Date Signed

AUTHORIZATION

This is your full and sufficient authority to release any and all medical/health records/information concerning myself to your:

Physician: _____ at _____

Chiropractor: _____ at _____

Physiotherapist: _____ at _____

Insurance Company/Adjustor _____ at _____

Dated at Regina, Saskatchewan this _____ day of _____, _____.

Signature: _____