Patient Health History Form (1/2)

3612 Green Moss Lane, Regina, SK S4V 1M2

Name: _____ **Date of initial visit:** _____
Address: _____ **Phone #:** _____
City: _____ **Postal Code:** _____ **Cell #:** _____
DOB: _____ / _____ / _____ **Work #:** _____
Day Month Year
E-mail Address: _____
Occupation: _____ **Emergency Contact:** _____
Referred By: _____ **Emergency Contact: Ph#:** _____
Physician's Name: _____ **Phone #:** _____
Allergies: _____
Sports & activities: _____
Current medications: _____
_____

Are you under medical care for any of the following: (circle)

Heart Conditions	High/Low blood pressure	Fainting or Dizziness
Varicose Veins	Phlebitis/Circulatory problems	Headaches or Migraine
Neck Injury	Back Injury	Jaw or Ear pain
Osteoporosis	Rheumatoid Arthritis	Osteoarthritis
Cancer	Kidney Disease	Skin conditions
Diabetes	Asthma/Respiratory	Fibromyalgia
Crohn's Disease	Pelvic Inflammatory Disease	Epilepsy
Nervous Disorders	Whiplash	other:

Patient Health History Form (2/2)

3612 Green Moss Lane, Regina, SK S4V 1M2

Have you received care from any of the following: (circle)

Physiotherapist	Chiropractor	Massage Therapist
Naturopath	Acupuncture:	Other: _____

Reason for treatment:_____ Number/duration of treatments: _____

Have you had surgery in the past? If yes, for what? _____

Have you had any fractures/sprains in the past? If yes, where? _____

Have you had any serious illnesses in the past? If yes, what? _____

Did the current injury result from a motor vehicle accident or workplace injury? _____

Have you had any of the following regarding your current condition: (circle)

Physician's examination	x-ray	other diagnostic tests

What relieves your pain? _____
What aggravates your pain? _____

Signature of Patient or Guardian: _____