Health History Form - CHIROPRACTIC

WELCOME TO OUR OFFICE - Please complete all requested information. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe that your condition will respond to chiropractic care, we will not accept your case. Thank you.

Name:			Date:
Address:	Apt #:	City:	Postal Code:

Tel # (home)	Tel #: (cell)	Tel #: (work)

Date of Birth: (day/month/year) / /	Age:	Marital Status (please circle): M S D W	Email:

Health Card # - with version code (letters):	Medical Doctor's Name:
Is this a W.S.I.B. or work related injury?	Is this a result of a motor vehicle accident?

What is your major complaint?
Please describe your symptoms:

What makes is worse?	What makes it better?

List previous falls, accidents, and injuries:
List any illnesses and surgeries:
List any medications you are taking:
What treatments have you received?

Have you had x-rays taken within the last two years?	**Females:** Do you suffer from PMS/dysmenorrhea?

Have you seen a chiropractor before? (name)	When?	Why?
Are you a smoker?	# of cigarettes per day	Recreational activities:

Occupation:	How did you find out about our office?

Is there anything else the doctor should be aware of?

LIST ANY FAMILY MEMBERS WHO SUFFER FROM THE FOLLOWING:

Arthritis	Cancer	High Blood Pressure	Heart Disease
Stroke	Diabetes	Other	

Please complete other side