

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Sex: Male  Female  Date of Birth (DD/MM/YYYY): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Phone # (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
Emergency Contact Name and Phone Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_

Family Doctor Name and Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ What do you do mostly?(sit/stand/etc) \_\_\_\_\_  
Have you received massage therapy before? \_\_\_\_\_  
How did you hear about our clinic? \_\_\_\_\_

Please describe your present complaint: \_\_\_\_\_

When did it occur? \_\_\_\_\_ How did it occur? \_\_\_\_\_

Have you ever had a similar problem to your current complaint? \_\_\_\_\_  
Have you received any treatment for this condition, and if so what kind of treatment? \_\_\_\_\_

Are you currently receiving treatment from another healthcare professional? Y/N  
If yes, for what? \_\_\_\_\_

Overall how is your general health? \_\_\_\_\_

Any prior surgery? \_\_\_\_\_  
Prior hospitalizations? \_\_\_\_\_  
Have you broken any bones? \_\_\_\_\_

Do you have any internal pins, wires, artificial joints or special equipment? Y/N  
If yes, what and where? \_\_\_\_\_

Do you have any medical conditions? \_\_\_\_\_

Do you currently take any prescription or over the counter medications or vitamins/nutritional supplements? Y/N  
If yes, specify name and reason for taking: \_\_\_\_\_

**I hereby authorize Taunton Chiropractic and Health Centre, with my prior knowledge, to release or to obtain any health information from my other healthcare providers as my be require for the management of my case.**

**I have read an understand the Taunton Chiropractic and Health Centre fee schedule and the 24-hour cancellation policy.**

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Family Health History**

Have your grandparents, parents or siblings ever been diagnosed with any of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> High blood pressure          | <input type="checkbox"/> Rheumatoid Arthritis  |
| <input type="checkbox"/> Heart disease                | <input type="checkbox"/> Osteoarthritis        |
| <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Neurological problems |
| <input type="checkbox"/> Diabetes (Type I or Type II) | <input type="checkbox"/> Cancer                |
| <input type="checkbox"/> Thyroid / Hormone problems   | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Breathing or lung problems   | <input type="checkbox"/> Other specify:        |

### Client Health History

\*Please **check** anything which is causing you problems right now\*

*Cardiovascular:*

- High Blood Pressure
- Low Blood Pressure
- Congestive heart failure
- Heart Attack
- Phlebitis
- Varicose veins
- Stroke/TIA
- Pacemaker/ICD/or similar
- Heart Disease
- Aneurysm

*Respiratory:*

- Chronic Cough
- Shortness of breath
- Bronchitis/Emphysema
- Asthma

*Other:*

- Rashes
- Itching
- Bruise Easily
- Heat Cold intolerance
- Loss of sensation (where?)
- Dry Skin
- Diabetes
- Hepatitis
- Tuberculosis (TB)
- HIV
- Herpes
- Other Skin conditions:

*Musculoskeletal:*

- Back Ache
- Swollen Joints
- Foot Pain L / R
- Shoulder Pain L / R
- Elbow Pain L / R
- Wrist Pain L / R
- Hand Pain L / R
- Hip Pain L / R
- Knee Pain L / R
- Arthritis
- Weakness
- Loss of Strength
- TMJ Problems L / R

*Head/Neck:*

- Seizures/Epilepsy
- Deafness
- Earache
- Blurred Vision
- Double Vision
- Loss of Vision
- Enlarged Glands
- Speech Problems
- Headaches
- Migraines
- Frequent Colds
- Sinus Problems

*Women:*

- Pregnant? Due: \_\_\_\_\_
- Menstrual cramps
- Hot Flashes
- Breast pain/lump
- Other: \_\_\_\_\_

Allergies/Hypersensitivities: \_\_\_\_\_

Type of reaction: \_\_\_\_\_

Other Health information you want us to know: \_\_\_\_\_

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