

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: _____
