Name ______________________________ Birth date ____________

Street Address ______________________ City of ____________ Postal Code ________

Home ☎ ____________ Work ☎ ____________ E-Mail ______________________

Your Occupation ______________________ Who Referred You? ______________________

Physician Name / Address ______________________________ Extended Health Care? ❒ Yes ❒ No

Reason for therapy? ____

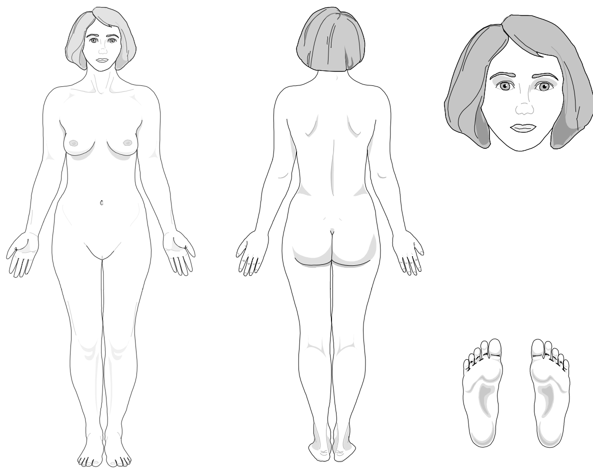
If you're feeling muscle or joint discomfort, would you describe it as:
❒ sharp ❒ dull ❒ achey ❒ throbbing
❒ burning ❒ pins and needles ❒ other _________

How often do you feel this?
❒ it comes & goes ❒ frequently ❒ constantly

What is the intensity of this discomfort?
0 1 2 3 4 5 6 7 8 9 10
No pain Intolerable

This discomfort is affecting your:
❒ work ❒ activity / sports ❒ home life ❒ sleep

Please illustrate: × areas of pain ⌿ areas of tingling (pins & needles) ✓ areas of no symptoms



Health History ☑ current conditions ☒ experienced in the past

Muscle, Skeletal and Nervous Systems
❒ tension or migraine headaches
❒ whiplash / motor vehicle accident
❒ neck or shoulder pain or stiffness
❒ back or hip pain or stiffness
❒ upper extremity weakness or tingling
❒ lower extremity weakness or tingling
❒ head trauma or concussion
❒ loss of co-ordination or dizziness
❒ sleep or personality changes
❒ light-headedness / fatigue
❒ epilepsy / seizures
❒ TMJ or tooth, jaw or ear pain
❒ vision or hearing difficulty or loss
❒ degenerating discs
❒ osteo or rheumatoid arthritis
❒ osteoporosis or bone disease
❒ spasm & strain or sprain
❒ tendonitis, fibrositis or bursitis
❒ fractures / pins, wires, plates
❒ carpal tunnel syndrome
❒ loss of sensation

Heart and Circulatory Systems
❒ high or low blood pressure
❒ chronic congestive heart failure
❒ heart disease / attack or stroke (CVA)
❒ chest pain or angina
❒ pacemaker or similiar device
❒ varicose veins or phlebitis
❒ cold hands & feet or swelling
❒ diabetes
❒ poor healing / bruise easily

Please rate your overall health
1 2 3 4 5 6 7 8 9 10
Poor Moderate Excellent

Skin and Immune Systems
❒ open sores, cuts or warts
❒ contagious skin disease
❒ tuberculosis or hepatitis
❒ HIV
❒ cancer
❒ allergies (food, environmental)

Breathing System
❒ asthma
❒ bronchitis or emphysema
❒ shortness of breath
❒ frequent colds or sinus
❒ chronic cough / smoking

Digestive System
❒ nausea or vomiting
❒ constipation
❒ rapid weight loss
❒ appetite changes
❒ diarrhea
❒ bad taste in mouth
❒ irritable bowel
❒ ulcers
❒ gall bladder problems

Genitourinary System
❒ painful urination
❒ unusual colour / odour
❒ hip or flank pain
❒ gynecological concerns
❒ pregnant currently

Life Questions
❒ I exercise regularly
❒ I feel good about life
❒ I have good sleeping patterns
❒ I have poor energy levels
❒ I suffer from too much stress

Prominent family illnesses ____

Current medications / other treatment ______________________________________

Major injuries or surgeries ____

I understand that all information gathered for this treatment is confidential, except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. I understand I will be asked for written authorization for release of any information. I have reviewed the fee schedule and cancellation policy, and I understand I must give at least 24 hours notice to reschedule my appointment. I will inform my therapist should anything change regarding my health status.

❒ Check here if you would prefer not to receive our clinic newsletter.

Today's Date ____________ Signature ______________________

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