

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? _____

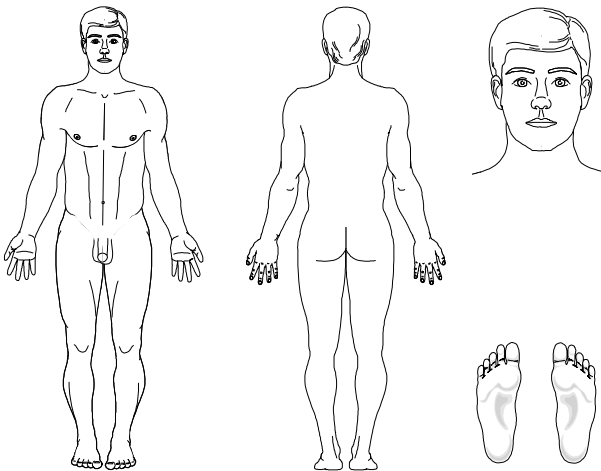
If you're feeling muscle or joint discomfort, would you describe it as:
 sharp dull aching throbbing
 burning pins and needles other _____

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

<p>Muscle, Skeletal and Nervous Systems</p> <input type="checkbox"/> tension or migraine headaches <input type="checkbox"/> whiplash / motor vehicle accident <input type="checkbox"/> neck or shoulder pain or stiffness <input type="checkbox"/> back or hip pain or stiffness <input type="checkbox"/> upper extremity weakness or tingling <input type="checkbox"/> lower extremity weakness or tingling <input type="checkbox"/> head trauma or concussion <input type="checkbox"/> loss of co-ordination or dizziness <input type="checkbox"/> sleep or personality changes <input type="checkbox"/> light-headedness / fatigue <input type="checkbox"/> epilepsy / seizures <input type="checkbox"/> TMJ or tooth, jaw or ear pain <input type="checkbox"/> vision or hearing difficulty or loss <input type="checkbox"/> degenerating discs <input type="checkbox"/> osteo or rheumatoid arthritis <input type="checkbox"/> osteoporosis or bone disease <input type="checkbox"/> spasm & strain or sprain <input type="checkbox"/> tendonitis, fibrositis or bursitis <input type="checkbox"/> fractures / pins, wires, plates <input type="checkbox"/> carpal tunnel syndrome <input type="checkbox"/> loss of sensation <p>Heart and Circulatory Systems</p> <input type="checkbox"/> high or low blood pressure <input type="checkbox"/> chronic congestive heart failure <input type="checkbox"/> heart disease / attack or stroke (CVA) <input type="checkbox"/> chest pain or angina <input type="checkbox"/> pacemaker or similiar device <input type="checkbox"/> varicose veins or phlebitis <input type="checkbox"/> cold hands & feet or swelling <input type="checkbox"/> diabetes <input type="checkbox"/> poor healing / bruise easily	<p>Skin and Immune Systems</p> <input type="checkbox"/> open sores, cuts or warts <input type="checkbox"/> contagious skin disease <input type="checkbox"/> tuberculosis or hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> cancer <input type="checkbox"/> allergies (food, environmental) <p>Breathing System</p> <input type="checkbox"/> asthma <input type="checkbox"/> bronchitis or emphysema <input type="checkbox"/> shortness of breath <input type="checkbox"/> frequent colds or sinus <input type="checkbox"/> chronic cough / smoking <p>Digestive System</p> <input type="checkbox"/> nausea or vomiting <input type="checkbox"/> constipation <input type="checkbox"/> rapid weight loss <input type="checkbox"/> appetite changes <input type="checkbox"/> diarrhea <input type="checkbox"/> bad taste in mouth <input type="checkbox"/> irritable bowel <input type="checkbox"/> ulcers <input type="checkbox"/> gall bladder problems <p>Genitourinary System</p> <input type="checkbox"/> painful urination <input type="checkbox"/> unusual colour / odour <input type="checkbox"/> hip or flank pain <input type="checkbox"/> gynecological concerns <input type="checkbox"/> pregnant currently <p>Life Questions</p> <input type="checkbox"/> I exercise regularly <input type="checkbox"/> I feel good about life <input type="checkbox"/> I have good sleeping patterns <input type="checkbox"/> I have poor energy levels <input type="checkbox"/> I suffer from too much stress
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Please rate your overall health
 1 2 3 4 5 6 7 8 9 10
 Poor Moderate Excellent

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 _____