Name _____ Birth date (DD/MM/YYYY) _____

Box Number _____ City of _____ Postal Code _____

Home ☎ _____ Work ☎ _____ E-Mail _____

Your Occupation _____ Who Referred You? _____

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

Symptoms? _____

Please describe your symptoms:

Sensation: ❒ sharp ❒ dull ❒ achey ❒ throbbing ❒ burning ❒ "numb" or pins and needles ❒ other

_____

Frequency: ❒ rarely experience ❒ comes & goes ❒ frequent ❒ constant

What is the intensity of this discomfort?

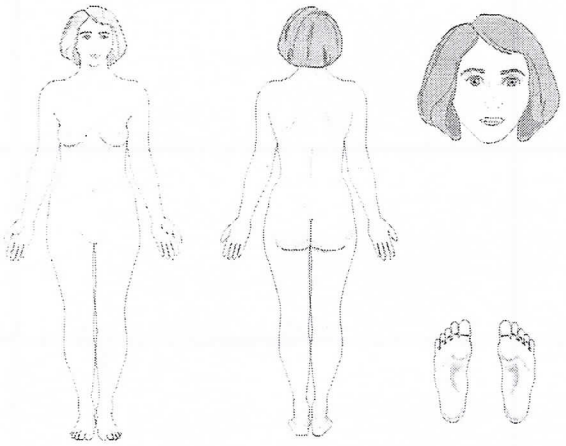
0 1 2 3 4 5 6 7 8 9 10

No pain Intolerable

This discomfort is affecting your:

❒ work ❒ activity / sports ❒ home life ❒ sleep

Please mark areas of: ✗ symptoms ✓ 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
- ❒ blood pressure high low
- ❒ 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 _____ When? _____

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 outside my circle of care. 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.

Today's Date _____ Signature _____

We regard your privacy very seriously. Please ask for a copy of our privacy and complaints policy, or visit our website