<u>**Patient Medical History**</u>

Full Name____ Date___________________

Address____

Postal Code____________Birthdate_________________Height_______Weight______

Phone (hm)________________Cell_______________Email______________________

Occupation_____________________________Medical Doctor____________________

How did you hear about this clinic?____

<u>For any of the following conditions that pertain to you, circle past or present.</u>

Anxiety/Nervousness	Present/ Past	High blood pressure	Present/ Past
Arthritis OA/RA	Present/ Past	Hemorrhoids	Present/ Past
Allergies	Present/ Past	Headaches	Present/ Past
AIDS/HIV	Present/ Past	Kidney/bladder problems	Present/ Past
Bruise easily	Present/ Past	Liver problems	Present/ Past
Bronchitis	Present/ Past	Migraines	Present/ Past
Blood clots	Present/ Past	Muscle/ligament injuries	Present/ Past
Broken bones	Present/ Past	Muscular pain/tension	Present/ Past
Cancer	Present/ Past	Menstrual difficulties	Present/ Past
Chronic pain conditions	Present/ Past	Nausea	Present/ Past
Cold hands/feet	Present/ Past	Osteoporosis/osteopenia	Present/ Past
Dizziness	Present/ Past	Ringing in ears	Present/ Past
Diabetes	Present/ Past	Respiratory problems	Present/ Past
Eye problems	Present/ Past	Stroke/Heart attack	Present/ Past
Ear problems	Present/ Past	Spinal curvature	Present/ Past
Fainting	Present/ Past	Skin conditions	Present/ Past
Fatigue	Present/ Past	Tendinitis	Present/ Past
Gastrointestinal problems	Present/ Past	Thyroid condition	Present/ Past
Hepatitis	Present/ Past	Ulcer/hernia	Present/ Past
Hypoglycemia	Present/ Past	Varicose veins	Present/ Past

Women:

Circle any of the following that apply to you. Pregnant (months)_________________
Endometriosis _________________

List/describe any conditions/symptoms, diseases/disorders you have, that are not listed above.____

List the area(s) and reason(s)/condition(s) for which you are seeking treatment.
____
____

Have you seen any other professional for this reason/condition? Y______ N_______
If yes, whom?____

List and date any surgery you have undergone. _________________________________
____
____

List and date any previous accidents or injuries. ________________________________
____
____

Are you presently taking any prescribed medications? Y ______ N______
If yes, list the medication and condition(s) for which it is being used.
____
____
____

We all value our time.

Please give <u>24 hours notice of a cancellation</u> or you will be charged for the full cost of the missed appointment.

Thank you for your consideration.

By my signature below, I authorize the collection, use and disclosure of personal information, as defined in the Personal Information and Protection Act (PIPA), required for treatment and/or any related administrative purpose. I understand that all my personal information is confidential, and must be treated in accordance with PIPA.

____
Signature