HEALTH INFORMATION FORM

Please provide us with the following medical information so that we can customize your therapy.

Today's Date: _____ (Month, Day, Year)

Patient Name: _____ Date of Birth (M,D,Y): _____ Gender: _____

Home Address: _____

Cell Phone Number: _____Other phone number: _____

Email: _____

Emergency contact: _____ Phone: _____

Physician Name: _____ Phone: _____

Do you have a physician referral/prescription? Yes ☐ No ☐

Who referred you for treatment? _____

Who is paying for treatment? (you, ICBC, Great West Life, etc): _____

Claim Number (if relevant): _____

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1. What is the current Injury that brought you here today? _____

2. Please list your main symptoms (e.g. stress, pain, stiffness, numbness/tingling, swelling, etc.). Circle the symptom that upsets you the most: _____

_____

3. List the medications you currently take: _____

_____

4. Please indicate the medical issues that you have had, and explain the treatment received:

Medical issue/events	Tick Yes if you ever had this issue Yes: ☑	Explain treatment received for this condition
Muscle or joint injury (e.g. sprained or pulled a muscle)	☐	
Broken bones/Fractures	☐	
Joint Replacements (hips, knees)	☐	
Headaches/Migraines	☐	
Dizziness, ringing in the ears	☐	
Memory Loss, confusion, easily overwhelmed	☐	
Brain Injury	☐	
High/Low blood pressure	☐	
Stroke, heart attack	☐ Date:	
Arthritis (osteoarthritis, rheumatoid)	☐	
Asthma, COPD, other breathing difficulties	☐	
Cancer	☐	
Osteoporosis, degenerative spine/discs	☐	
Digestive conditions (IBS, Crohns)	☐	
Scoliosis	☐	
Diabetes	☐	
Depression/Anxiety	☐	
Thyroid Condition	☐	
Parkinson's, Multiple Sclerosis	☐	
Epilepsy, seizures	☐	
Pregnancy	☐	If yes, how many children:
Serious Allergies	☐	
Other: (list)	☐	

Thank you for providing us with your medical information, this helps us to design therapies to suit your specific needs.