CONFIDENTIAL CASE HISTORY

Name: _____

Phone* H: _____ Email:* _____

C: _____ Date of Birth:* MM / DD / YYYY

W: _____ Occupation: _____

Address: _____

Postal Code: _____ Sex: Female Male

How did you find out about our clinic? _____

Family Physician: _____

Care Card #: _____

Primary area of concern: _____

How long has this condition existed? _____

Relieving factors: _____

Aggravating factors: _____

Previous accidents or major surgeries:

Date	Description

Do any of the following apply to you?

___ High/low blood pressure	___ Arthritis	___ Epilepsy
___ Heart condition	___ Kidney condition	___ Stroke
___ Headache/migraine	___ Digestive problems	___ Diabetes
___ Contagious condition	___ Respiratory condition	___ Cancer
___ Sleep disturbance	___ Circulatory problems	___ Allergies
___ Pregnancy	___ Recent surgery	___ Infections
___ Head injury	___ Disc/joint/spinal	___ Fractures
___ Spinal injury	___ Sprains/strains/dislocations	___ Fainting
___ PMS	___ Unexplained fatigue	___ Jaw pain

Other: _____

Please list any medications you are currently taking:

_____

_____

CANCELLATION POLICY: A minimum of 24 hours notice is required to cancel or change your appointment; otherwise, a late cancellation fee of the FULL amount of the treatment will be charged. Missed appointment fees outstanding for over 30 days will be subject to an additional collections fee of $20.

I have read, fully understand, and agree to the above cancellation policy:

Signature: _____ Date: _____