Date (Day/Month/Year): ____/____/____

CONFIDENTIAL PATIENT CASE HISTORY

NAME ________________________________ TELEPHONE (Home) ____________________

EMAIL ________________________________ TELEPHONE (Work) ____________________

ADDRESS _________________________ CITY _______________ POSTAL CODE __________

Occupation ______________________________ Employer ________________________________

Date of Birth (Day/Month/Year) ____/____/____ Male __ Female __ Height ______ Weight _____

Medical Doctor ___________________________ Previous Chiropractor ______________________

Who referred you to our clinic? ____

If a job-related injury:

Social Insurance Number ____________________ Date reported to Employer ____________________

What is the major reason for consulting our office? ____

____

How long have you had this condition? ____________________ Any past episodes? ______________

____

____

What activities or positions aggravate the problem? ____

____

____

What gives you relief? ____

____

____

Medication(s) taken ____

____

____

Have you had any major falls, accidents or blows to the head? ___________________________

____

____

____

Please circle what you would be interested in knowing more about:

ACUPUNCTURE *VITA-PULSE MAGNETIC FIELD THERAPY* *CHIROPRACTIC CARE*

BIO-CRANIAL THERAPY *CHILDREN'S HEALTH* *LASER THERAPY*

INFANT COLIC *NON-NEEDLE ELECTRIC ACUPUNCTURE* *HEADACHES*

ARTHRITIS *MEASURING MERIDIAN ENERGY* *DIGESTIVE DISTURBANCES*

MATRIX REPATTERNING *OTHER CONDITION NOT MENTIONED*