

Please indicate the conditions that you have experienced or are currently experiencing:

Cardiovascular:

- High Blood Pressure
- Low Blood Pressure
- Congestive Heart Failure
- Heart Attack
- Phlebitis / Varicose Veins
- Stroke / CVA
- Pacemaker or similar device
- Heart Disease
- Dizziness / Vertigo
- Seizures
- Hemophilia

Respiratory:

- Asthma
- Bronchitis
- Emphysema
- Chronic Cough
- Shortness of Breath

Digestive:

- Constipation
- Crohn's Disease
- Colitis
- Irritable Bowel Syndrome
- Ulcers

Head and Neck:

- Headaches
- Migraines
- Vision Problems
- Vision Loss
- Ear problems
- Hearing Loss
- Jaw Pain

Muscle / Joint:

- Neck
- Back (lower)
- Back (mid)
- Back (upper)
- Shoulders
- Elbow
- Wrist / Hand
- Hip
- Knee
- Ankle / Foot
- Spine
- Jaw

Skin Conditions:

- Eczema
- Psoriasis
- Rash
- Warts
- Open Sores

Infectious Conditions:

- Skin Conditions

Describe: _____

- Respiratory Conditions:

Describe: _____

- Hepatitis
- HIV
- AIDS
- Herpes

Women:

Chance of Pregnancy? Y / N

Due Date: _____

- Gynecological Conditions

List: _____

- Menstrual Problems
- Menopausal Problems

Other:

- Loss of Sensation

Where? _____

- Diabetes

Onset: _____

Type: _____

- Epilepsy
- Seizures
- Cancer

Type/Location: _____

- Arthritis
- Osteoporosis
- Mental Illness
- Fibromyalgia
- Chronic Fatigue
- Scoliosis
- Polio / Post polio

Is there a family history of any of the above? Please list:

Do you have any other medical conditions or additional information that you would like to provide?

Please note that all information provided will be kept strictly confidential unless allowed or required by law. Your written permission will be required to release any information.

WAIVER:

Because certain chiropractic treatment modalities are contraindicated under certain conditions, I affirm that all information provided in this health history form is complete and correct to the best of my knowledge. I agree to inform my chiropractor of any changes to my medical profile.

Signature

Date

kw health connection

chiropractor • naturopath • massage

(for office use only)

Date: _____ Chart No. _____

OHIP #: _____

Name: Last _____ First _____ Initial _____

Address _____

City _____ Prov. _____ Postal _____

Phones (H) _____ (W) _____ Cell _____

Email _____

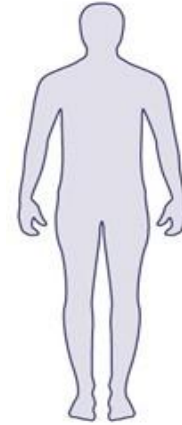
(email addresses will only be used for appointment reminders and our monthly newsletter)

Age _____ Date of Birth (D/M/Y) _____ / _____ / _____ Sex (M) _____ (F) _____

Employer _____ Position _____

Married ___ S ___ D ___ W ___ Children # ___ Spouse Name _____

Emergency Contact _____ Phone _____



FRONT

Do you have 3rd party Extended Health Benefits through work or otherwise? Y/N

Do you have any allergies? _____

Are you on any medications? _____

Name of family physician _____ Last visit _____

Address _____ Phone # _____

Can we correspond with your family physician to send progress notes? Y/N

Is any member of your family being treated at 'kw health connection'? Y/N

Name _____ Relation to you _____

Have you ever had Chiropractic care before? Y/N When? _____

Satisfied? _____

What is your main reason for seeking Chiropractic care today? (Please be as specific as possible with any complaints or concerns you have).

| mark on diagram to right using the letter key below the diagrams |

When did you first notice this problem? _____

Have you lost work because of it? _____

Will you be filing a WSIB claim due to a work related accident? Y/N

If yes, Claim # _____ Adjuster Name _____

Have you been in a recent Auto accident? Y/N If so, will you or have you already made an Auto Insurance claim? Y/N Claim # _____

Adjuster Name _____ Phone _____

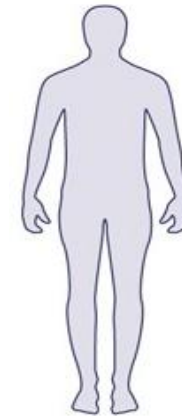
Do you have any previous injuries, surgeries, or illnesses that the Doctor should be aware of?

How did you hear of 'kw health connection'? Person's Name _____

Yellow Pages _____ Newspaper _____ Other _____

I have been notified of the fee structure and certify that the above is correct:

Please circle the number that best describes your pain
 0 1 2 3 4 5 6 7 8 9 10
 none mild moderate severe



BACK

Please mark on the image above the areas of:

Pain	(X)	Burning	(B)
Numbness	(/)	Ache	(A)
Weakness	(O)		

Fees: Emergency: \$175.00
 Initial Examination: \$95.00
 Subsequent Treatments: \$45.00
 Double Treatment: \$85.00
 Chiro + Acupuncture: \$70.00

Signature _____ date _____