

# HEALTH INFORMATION FORM

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

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

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