EDSON FAMILY CHIROPRACTIC AND NATURAL HEALTH CENTRE

PATIENT INFORMATION Date: _____

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms.

Name_____

☐ Male ☐ Female DOB (d/m/y) ____/____/____ Age_____

Street Address_____

City_____ Province_____ Postal Code_____

Home Phone_____ Work Phone_____ Cell_____

Email Address_____

Occupation_____

Sporting activities/Hobbies_____

Emergency Contact_____ Phone_____

Family Physician_____ Phone_____

Are you currently seeing any other health care professionals? ☐ Y ☐ N

Please specify_____

MEDICAL HISTORY

Please list the medications you are on: _____

_____

Please list any surgeries you've had: _____

_____

Any other injuries (current/past 5 years): _____

_____

Have you attended physiotherapy before? ☐ Y ☐ N

Have you had any imaging (X-rays, MRI, Ultrasound) in the last 2 years? ☐ Y ☐ N

When / Where_____

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Please check if you have any of the following conditions:

- ☐ Pregnant
- ☐ Fractures
- ☐ Heart problems/abnormalities
- ☐ Stroke
- ☐ Cancer
- ☐ Back/neck injuries
- ☐ Diabetes
- ☐ Respiratory problems/asthma
- ☐ Arthritis
- ☐ Vision/hearing problems
- ☐ Allergies
- ☐ Osteoporosis
- ☐ High blood pressure
- ☐ Pacemaker
- ☐ Metal implant
- ☐ Smoker
- ☐ High cholesterol
- ☐ Lung disease
- ☐ Chronic or recurrent cough
- ☐ Epilepsy
- ☐ Unexplained weight loss
- ☐ Night pain

Other_____