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

Head and Neck:
- ☐ Headaches
- ☐ Migraines
- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Ear problems
- ☐ Hearing Loss
- ☐ Jaw Pain

Infectious Conditions:
- ☐ Skin Conditions

Describe:_____

_____

- ☐ Respiratory Conditions:

Describe:_____

_____

- ☐ Hepatitis
- ☐ HIV
- ☐ AIDS
- ☐ Herpes

Respiratory:
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Shortness of Breath

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

Women:

Chance of Pregnancy? Y / N

Due Date:_____

- ☐ Gynecological Conditions

List:_____

_____

- ☐ Menstrual Problems
- ☐ Menopausal Problems

Digestive:
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Ulcers

Skin Conditions:
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rash
- ☐ Warts
- ☐ Open Sores

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. _____

Dr. Colin Leis • 417 King Street West, Kitchener N2G 1C2 • 519.576.2222

Name: Last _____ First _____ Initial _____

Address _____

City _____ Prov. _____ Postal _____

Phones (H) _____ (W) _____ Cell _____

Email _____

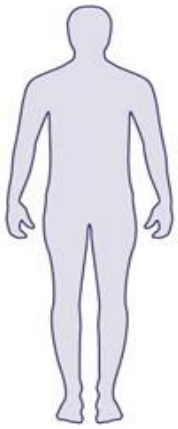
(email addresses will only be used for appointment reminders and our monthly newsletter)

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

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

none mild moderate severe

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

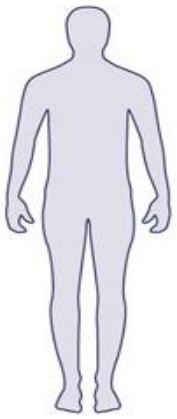
Name _____ Relation to you _____

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 |



BACK

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?

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: $70.00

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

Yellow Pages _____ Google _____ Other _____

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

Signature **date**