Health History Form

Name: _____ Date: _____
Address: _____ Telephone (home): _____
City: _____ Postal Code: _____ (Cell): _____
Occupation: _____

Email address: _____ Date of birth (mm/dd/yy) _____
Emergency Contact: _____ Telephone: _____
Do you have Extended Health Care Insurance coverage for chiropractic? ___Yes___No
Name of Insurance Provider: _____
General Practitioners name: _____ Telephone: _____
Permission to consult with your Doctor: ____Yes____No Initials: _____

Primary Complaint: _____
Onset of symptoms: _____ Aggravates/Relieves? _____
Have you seen any other health professionals for this? ____Yes ____No
Who? _____ When? _____
Have you experienced a similar condition in the past? If yes, when? _____

Please indicate conditions that you are experiencing, or have experienced:

Respiratory
[ ] Chronic cough
[ ] Shortness of breath
[ ] Asthma
[ ] Sinus Problems
[ ] Allergies
[ ] COPD
[ ] Other: _____

Cardiovascular
[ ] High/Low Blood Pressure
[ ] Blood clots
[ ] Heart Disease/Failure
[ ] Myocardial Infarction
[ ] Stroke
[ ] Pacemaker/ electric device
[ ] Other: _____

Digestive
[ ] Constipation
[ ] Diarrhea
[ ] IBS
[ ] Gas/bloating
[ ] Liver Disease
[ ] Other: _____

Nervous System
[ ] Concussion
[ ] Loss of sensation
[ ] Numbness/Tingling
Where? _____
[ ] Herpes/Shingles
[ ] Chronic Pain
[ ] Headaches

Musculoskeletal
[ ] Ankle Injuries
[ ] Fractures/Strains/Sprains
[ ] Bone or Joint Disease
[ ] Arthritis: Type _____
[ ] Low back/hip/leg pain
[ ] Neck/Shoulder/Arm pain
[ ] TMJ/ Jaw Pain

Other
[ ] Pregnant?
_____Yes _____No
[ ] Cancer: _____
[ ] Kidney Disease
[ ] Vision/Hearing
[ ] Diabetes: Type_____
[ ] Mental Health

Current Medications or Supplements

Name	Condition	Name	Condition

Surgeries

Type	Approx. Date	Type	Approx. Date

Motor Vehicle Accident

Date	Injuries Sustained

Other Accidents or Injuries: _____ Date: _____
Presence of internal pins, wires, artificial joints, special equipment? _____

Have you ever received Chiropractic care before? ___ Yes ___ No
Other therapies? (Physio, Massage, Acupuncture) ___ Yes ___ No

Do you have any other conditions not listed, or is there anything else you wish the Practitioner to know?
_____

Please indicate which body parts you consent to be treated:
Head/Face ___ Neck ___ Shoulders/Arm ___ Hips/Legs ___ Gluteals ___ Abdomen____
Inner thigh ___ Back ___ Consent to all: _____ (Initials)

Consent Form:
It is important that you fill out this health history form to ensure that it is safe for you to receive treatment. If your health status changes, please notify your therapist before your next treatment. All information gathered will be kept confidential except as required by law or to facilitate an assessment or treatment.
I agree to communicate with my therapist at any time if I have questions, if I feel uncomfortable, or if I feel my well-being is being compromised. I will give consent to my chiropractor to treat only the areas of my body that we discussed in the treatment plan. **Initials** _____
I am aware that I may remove only the clothing that I am comfortable removing. I know that I have the right to stop or modify treatment at any time. It is my choice to receive Acupuncture or Chiropractic care. **Initials** _____
Cancellation Policy: There is a $25.00 charge for the first missed appointment, or appointments cancelled with less than 24 hours notice. There will be a full treatment charge for subsequent missed appointments. The 30-75 min time slot is reserved specifically for you. If you are unable to keep your appointment please notify the office at least 24 hours before your appointment to enable others to attend a treatment.

Signature: _____ **Date: _____**
Parent/Guardian Signature: _____ **Date: _____**
(If under the age of 16)

Permission Form
I, _____ give permission for the clinic of Niagara Therapeutics Inc. to send informational material via mail or email? Personal information collected by the clinic will not be used for any other purposes.
Do you wish to receive appointment reminder emails? ___ Yes ___ No

How did you hear about our clinic?
Facebook _____ Website _____ Our Sign _____ Yellow Pages _____ Other? _____
Family/Friend/Co-Worker_____ Who? _____

Signature: _____ **Date**: _____