Kingston West Family Chiropractic
dedicated to excellence in natural family health

Health History Form

Confidential when completed

Name: _____ Date of birth: _____

Phone: (day) _____ (evening) _____ (cell) _____

Address: _____ Postal Code: _____

Email address: _____ Occupation: _____

Referred by: _____ Previous massages: Yes ☐ No ☐

Physician's name: _____ Phone: _____

Address: _____

List and date any injuries, fractures, dislocations, surgeries, artificial joints, pins, wires, etc. and medications or treatments used to treat them:

_____

_____

_____

List all other therapeutic treatments: _____

List any hereditary conditions: _____

General health status (circle): Very Healthy | Healthy | Fatigue Easily | Injured | Stressful State | Chronic Illness or Ailment

Please indicate the conditions that apply to you below: **C** – Current **P** – Previous

Musculo-skeletal

	C	P
Jaw/tmj	☐	☐
Neck	☐	☐
Shoulder r/l	☐	☐
Arm r/l	☐	☐
Back u/m/l	☐	☐
Hip r/l	☐	☐
Leg r/l	☐	☐
Knee r/l	☐	☐
Ankle r/l	☐	☐
Joint pain/stiffness	☐	☐
Scoliosis	☐	☐

Nervous system

	C	P
Fibromyalgia	☐	☐
Chronic pain	☐	☐
Numbness/tingling	☐	☐
Insomnia	☐	☐
Dizziness	☐	☐

Respiratory

	C	P
Chronic cough	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Breathing difficulties	☐	☐
Sinus congestion	☐	☐

Smoker? How long? _____

per week _____

Digestive

	C	P
Constipation	☐	☐
Diarrhea	☐	☐
Irritable bowel	☐	☐
Crohn's disease	☐	☐
Frequent nausea	☐	☐
Liver pathologies	☐	☐
Gallbladder	☐	☐
Ulcer	☐	☐
Hemorrhoids	☐	☐

Cardiovascular

	C	P
High blood pressure	☐	☐
Low blood pressure	☐	☐
Congestive heart failure	☐	☐
Myocardial infarction	☐	☐
Stroke	☐	☐
Heart disease	☐	☐
Phlebitis	☐	☐
Varicose veins	☐	☐
Pacemaker or other	☐	☐

Infections

	C	P
Skin conditions	☐	☐
Tuberculosis	☐	☐
Hepatitis (a, b, c)	☐	☐
HIV/AIDS	☐	☐
Herpes	☐	☐
Plantar's warts	☐	☐
Psoriasis	☐	☐

See Reverse...

Pathologies

	C	P
Thyroid dysfunction	☐	☐
Hemophilia	☐	☐
Diabetes	☐	☐
Rheumatoid arthritis	☐	☐
Osteoarthritis	☐	☐
Osteoporosis	☐	☐
Cancer	☐	☐
Epilepsy	☐	☐
Blood disorder	☐	☐

General

	C	P
Bruise easily	☐	☐
Hearing loss	☐	☐
Vision loss	☐	☐

List Allergies:_____

_____

Frequent headaches	☐	☐
Migraines	☐	☐

Other:_____

Women

	C	P
Menstrual problems	☐	☐
Gynecological surgeries	☐	☐
Endometriosis	☐	☐

Gynecological pathology

Pregnancy due:_____

History of complications during pregnancy, please specify:

_____

_____

Other:_____

What is your main goal of treatment? _____

_____

_____

_____

_____

Please mark with an circle on the scale below, the level or intensity of pain you are presently experiencing.

Absolutely pain free **[1 2 3 4 5 6 7 8 9 10]** Worst pain you have ever experienced

Please mark the areas on your body where you feel the described sensation:

Aching - •

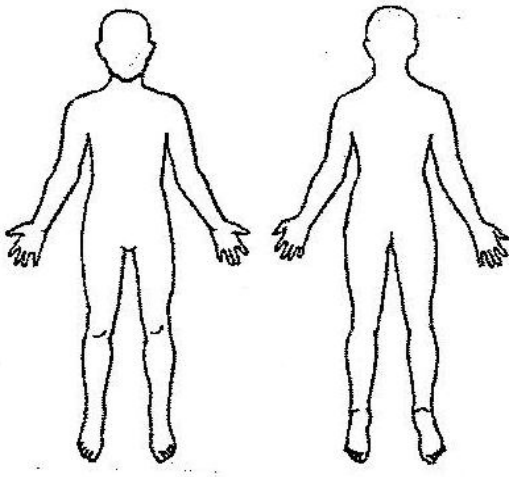
Numbness - ■

Pins and needles - ▲

Burning – **X**

Stabbing - **#**

Other - ÷



Privacy Policy: Our privacy policy is available to view or print on our website: **www.kwfc.ca or copies can be found in our clinic.**

Cancellation Policy: This time is reserved for you. If you are unable to keep this appointment please notify us with a minimum of **24 hours** in advance or you will be charged in full for the missed appointment. Initials ____

I have stated all medical conditions and will update my therapist of any changes in my health status. I have the right to stop, change or request modification of my treatment and consent to be treated for therapeutic massage by a registered massage therapist.

Signature: _____

Date: _____

UPDATED	INITIALS