

Please indicate conditions you are experiencing or have experienced:

<p><u>Cardiovascular</u></p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Chronic congestive heart failure</p> <p><input type="checkbox"/> Heart attack</p> <p><input type="checkbox"/> Phlebitis / varicose veins</p> <p><input type="checkbox"/> Stroke/CVA</p> <p><input type="checkbox"/> Pacemaker or similar device</p> <p><input type="checkbox"/> Heart disease</p> <p>Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Respiratory</u></p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Emphysema</p> <p>Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>Infections</u></p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Skin conditions</p> <p><input type="checkbox"/> TB</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> Herpes</p> <p><u>Other Conditions</u></p> <p><input type="checkbox"/> Loss of sensation, where? _____</p> <p><input type="checkbox"/> Diabetes, onset: _____</p> <p><input type="checkbox"/> Allergies/hypersensitivity to what? _____</p> <p style="margin-left: 20px;">Type of reaction: _____</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Cancer, where? _____</p> <p><input type="checkbox"/> Skin conditions, what? _____</p> <p><input type="checkbox"/> Arthritis, type? _____</p> <p>Is there a family history of arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>Head/Neck</u></p> <p><input type="checkbox"/> History of headaches</p> <p><input type="checkbox"/> History of migraines</p> <p><input type="checkbox"/> Vision problems</p> <p><input type="checkbox"/> Vision loss</p> <p><input type="checkbox"/> Ear problems</p> <p><input type="checkbox"/> Hearing loss</p> <p><u>Women</u></p> <p><input type="checkbox"/> Pregnant, Due: _____</p> <p><input type="checkbox"/> Gynaecological conditions, What? _____</p> <p>Overall, how is your general health? _____</p> <p>Primary Care Physician: _____</p> <p>Address & Phone Number: _____</p> <p>_____</p> <p>_____</p>
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<p>Current Medications: _____</p> <p>_____</p> <p>Condition it treats: _____</p> <p>_____</p> <p>Are you currently receiving treatment from another health care professional? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, for what? _____</p> <p>_____</p> <p>Surgery – Date: _____</p> <p>Nature: _____</p> <p>Injury – Date: _____</p> <p>Nature: _____</p>	<p>Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What? _____</p> <p>Do you have any internal pins, wires, artificial joints or special equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What? _____</p> <p>Where? _____</p>
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Notes:

<p>Date of Initial Health History: _____</p> <p>Update 1: _____</p> <p>Update 2: _____</p> <p>Update 3: _____</p>

Our centre is committed to conforming to federal privacy legislation effective January 1, 2004. All information collected is kept strictly confidential, unless the release of this personal information is authorized by yourself, the undersigned, or is required by law. I, the undersigned, believe that all information on this form is true to the best of my knowledge.

Signature: _____

Date: _____