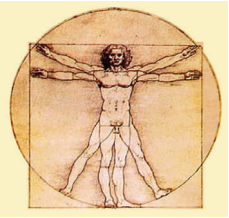


# Huronia Chiropractic & Wellness Centre
## Confidential Case History

237 Mapleview Dr. E. Suite 4
Barrie ON L4N 0W5
Phone: 705.739.1155
Fax: 705.739.2280

## Client Information

Name _____

Address _____City_____P.C._____

Phone: Home _____Work _____Cell _____

Date of Birth _____

Occupation _____Hours per day _____

Where did you hear about our clinic? _____

Previous massage experience: □ Yes □ No Frequency _____

Reason for coming: □ Relaxation □ Pain relief Other _____

**FAMILY DOCTOR:** _____ **ADDRESS:** _____

**EMERGENCY CONTACT: Name:** _____ **Home #:** _____

**Relationship:** _____**Work #:** _____

## Please check any of the conditions below that you experience now or have in the past:

**Respiratory:**
- □ Chronic Cough
- □ Shortness of Breath
- □ Bronchitis
- □ Emphysema
- □ Asthma

**Cardiovascular:**
- □ Low Blood Pressure
- □ High Blood Pressure
- □ CCHF
- □ Heart Attack
- □ Varicose Veins (Phlebitis)
- □ Stroke/CVA
- □ Pacemaker
- □ Heart Disease

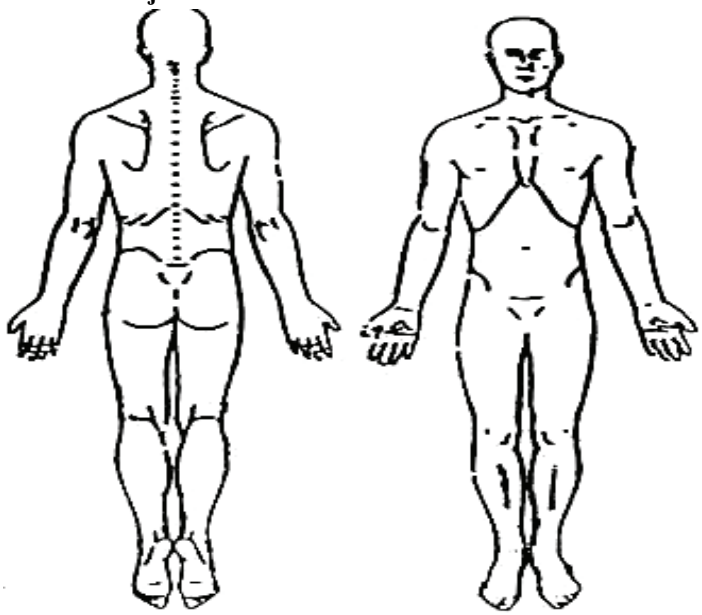
**Head/Neck:**
- □ Vision Poblems
- □ Vision Loss
- □ Hearing Problems
- □ Hearing Loss

**Infections:**
- □ Hepatitis
- □ Skin Conditions
- □ HIV / Aids
- □ Tuberculosis

**Other Conditions:**
- □ Loss of Sensation
- □ Cancer
- □ Epilepsy
- □ Arthritis
- □ Diabetes (onset:_____)

**Please identify areas of current symptoms by indicating on the diagram below:**

**X for pain** **O for joint/muscle stiffness** **/// for areas of numbness/tingling**



Number of colds per year:_____ Allergies: _____
Headaches: □ Yes □ No How often?: _____
Migraines: □ Yes □ No How often?: _____
Present Painful area: _____
Chronic Painful area: _____
Recent surgery: _____
Fractures/pins/wires: _____
Artifical joints/limbs: _____
Medications (include ailment): _____
Are you pregnant? □ Yes □ No Due date: _____
Current involvement with other health care professionals?: _____

□ **The information on this form is complete and accurate to the best of my knowledge and I will inform my therapist of any changes in my health status.**

□ **I understand that the information given on this form is confidential and will be used only for the therapist's clinical records. There will be no release of this information to anyone without my written authorization.**

□ **It is my responsibility to communicate with the therapist. I understand that during the course of treatment I am encouraged and have the right to ask questions regarding the procedure or effects of my treatment. At any time before or during, I can ask the therapist to alter or stop the course of treatment.**

□ **We require 24 hours notice for appointment cancellations. You will be billed for missed appointments if less than 24 hours notice of cancellation is given. This missed appointment fee will not be reimbursed by extended health coverage or Motor Vehicle Accident insurance**

Signature _____ Date _____