

Athletic Rehabilitation and Performance Centre

Health History

Name:		Date:
Address:	City:	Postal Code:
Telephone # (Home):	Telephone # (Cell):	Telephone # (Work):
Date of Birth (Day/Month/Year):	Age:	Marital Status:
E-mail address:	Medical Doctor Name:	
Is this a W.S.I.B or work related injury?		Is this a motor vehicle accident?
What is your major complaint?		
Please describe your symptoms?		
What makes it worse?		What makes it better?
List any previous falls, accidents, and injuries:		
List any illnesses and surgeries:		
List any medications you are taking:		
Have you received previous treatment for this problem?		
Have you seen a Chiropractor before? (Name)		When?
		Why?
Are you a smoker?	# Of Cigarettes per day?	Recreational activities?
Occupation:		How did you find out about the office?
LIST ANY FAMILY MEMBERS WHO SUFFER FROM THE FOLLOWING:		
Arthritis:	Cancer:	High Blood Pressure:
Heart Disease:	Stroke:	Diabetes:
Other:		