LEACOCK FAMILY CHIROPRACTIC

420 Leacock Drive, Barrie Ont L4N 5G5

Health History

Name:_____ Date:_____

Do you have any cardiovascular problems? Please Circle.

High Blood Pressure Low Blood Pressure Heart Disease History of Stroke
History of Heart Attack Chronic Congestive Heart Failure Pacemaker
Phlebitis Varicose Veins Other_____

Do you have any respiratory insufficiencies? Please circle.

Chronic Cough Bronchitis Asthma Emphysema Shortness of Breath Other _____

Do you have any infectious conditions? Please circle.

Infectious Skin Condition - Please Specify_____
Tuberculosis Hepatitis HIV Other_____

Do you have any neurological problems? Please circle.

Numbness Pins and Needles Paralysis Other_____ Location_____

Have you ever been diagnosed with a chronic condition? Please circle.

Fibromyalgia Diabetes Arthritis Cancer MS MD Any Other Condition_____

Any Falls or Accidents or Surgeries? _____

Any presence of internal pins, wires, artificial joints or special equipment? Yes No

Any vision or hearing loss? _____Any known allergies?_____

Do you suffer from joint pain, stiffness or inflammation? - Please Specify_____
_____

Do you have any skin conditions? _____

Are you currently taking any medications? Please Specify
_____

Are you pregnant, or planning a pregnancy? No Yes How far along?_____

How is your general health?_____ Primary Complaint_____

Signature_____