# HEALTH HISTORY FORM

Leacock Family Chiropractic

The information requested below will assist us in treating you safely. Feel free to ask any question about the information being requested. If your health status changes in the future, please let us know.

Name: _____ Date: _____ Birth Date (d/m/y): _____

Address: _____City:_____ Postal Code: _____

Phone: (home) _____ (work) _____ Cell number: _____

Email: _____ May we contact you via Email? Y / N

How did you hear about us? _____ Occupation: _____

**Please indicate conditions you are experiencing or have experienced.**

| | | |
|---|---|---|
| **Cardiovascular**<br>❑ high blood pressure<br>❑ low blood pressure<br>❑ chronic congestive heart failure<br>❑ heart attack<br>❑ phlebitis/varicose veins<br>❑ stroke/CVA<br>❑ pacemaker/similar device<br>❑ heart disease<br><br>Is there a family history of any of the above? Yes ____ No _____ | **Respiratory**<br>❑ chronic cough<br>❑ shortness of breath<br>❑ bronchitis<br>❑ asthma<br>❑ emphysema<br><br>Is there a family history of any of the above? Yes ____ No ____<br><br>**Women**<br>❑ pregnant<br>due date _____<br>❑ gynecological conditions | **Other Conditions**<br>❑ loss of sensation (where?)<br>_____<br>❑ diabetes<br>(onset/type: _____)<br>❑ allergies/hypersensitive<br>❑ epilepsy<br>❑ cancer (where?)<br>_____<br>❑ arthritis_____<br>_____<br><br>Is there a family history of arthritis?<br>Yes _____ No_____ |
| **Infections**<br>❑ hepatitis<br>❑ TB<br>❑ HIV/AIDS<br>❑ skin conditions<br>_____<br>(e.g. psoriasis, eczema) | **Head / Neck**<br>❑ history of headaches<br>❑ history of migraines<br>❑ vision problems<br>❑ vision loss<br>❑ ear problems<br>❑ hearing loss | **In General**<br>Overall, how is your general health?<br>_____<br><br>Primary Care Physician:<br>_____<br>Address:<br>_____ |
| Current medications and the conditions they treat:<br>_____<br>_____<br>_____<br>_____ | Are you receiving treatment from another health care professional?<br>Yes _____ No _____<br><br>If Yes, for what?<br>_____ | Surgery date:<br>_____<br><br>Injury date: _____<br><br>Nature: _____<br><br>Is this a WSIB injury? _____ |
| Do you have any other medical conditions? (e.g. Digestive, hemophilia, osteoporosis, mental illness)<br>Yes _____ No _____<br>If Yes, what?<br>_____ | Do you have any internal pins, wires, artificial joints or special equipment?<br>Yes _____ No _____<br>If Yes, what?_____<br><br>Where?_____ | What is the reason you are seeking massage?<br>_____<br>Where do you feel current joint or muscle discomfort?<br>_____<br>Have you ever had a massage? |

Update 1: _____ By: _____ RMT

Update 2: _____ By: _____ RMT Patient's Signature: _____