LEACOCK FAMILY CHIROPRACTIC

420 LEACOCK DR BARRIE ON L4N 5G5

Historical Information

Patient's Name_____ Date_____ Age ____ Sex ____

Instructions: Please circle the correct response. Sign and date when completed.

Have you ever been diagnosed or told you had any of the following?

a)	Hardening of the arteries (arteriosclerosis)	YES	NO
b)	Heart or blood vessel disease	YES	NO
c)	Bone spurs on the neck bones (cervical-osterophytes)	YES	NO
d)	Whiplash injury (flexion-extension injury)	YES	NO
e)	Have any of your relatives ever suffered a stroke?	YES	NO
f)	Were you ever a smoker? From _____ to _____	YES	NO
g)	Do you take any medication on a regular basis? What? (Coumadin, Heparin, Aspirin, Anti-hypertensives, etc.) _____	YES	NO
h)	(Women Only) Have you ever taken oral contrceptives From _____ to _____	YES	NO

Have you ever experienced any of the following, even short temporary attacks?

a)	Blurred vision?	YES	NO
b)	Double vision?	YES	NO
c)	Complete loss of vision in one or both eyes?	YES	NO
d)	Ringing, buzzing or any noise in the ear(s)?	YES	NO
e)	Hearing loss in one or both ears?	YES	NO
f)	Slurred speech or other speech problems?	YES	NO
g)	Difficulty swallowing?	YES	NO
h)	Dizziness?	YES	NO
i)	Temporary lack of understanding?	YES	NO
j)	Numbness or loss of sensations?	YES	NO
k)	Any abnormal sensations?	YES	NO
l)	Weakness or loss of strength in arms or legs?	YES	NO
m)	Sudden collapse without loss of consciousness?	YES	NO

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Signature Date