TAUNTON CHIROPRACTIC
AND HEALTH CENTRE

Name:_____ Date:_____
Sex: Male ☐ Female ☐ Date of Birth (DD/MM/YYYY): _____
Address:_____City:_____Postal Code:_____
Phone # (H)_____ (W)_____ (C)_____
Emergency Contact Name and Phone Number:_____
Email Address: _____

Family Doctor Name and Address:_____
Occupation:_____What do you do mostly?(sit/stand/etc)_____
Have you received massage therapy before?_____
How did you hear about our clinic?_____

Please describe your present complaint:_____
_____
When did it occur?_____How did it occur?_____

Have you ever had a similar problem to your current complaint?_____
Have you received any treatment for this condition, and if so what kind of treatment?_____
_____
Are you currently receiving treatment from another healthcare professional? Y/N
If yes, for what?_____

Overall how is your general health?_____

Any prior surgery?_____
Prior hospitalizations?_____
Have you broken any bones?_____

Do you have any internal pins, wires, artificial joints or special equipment? Y/N
If yes, what and where?_____

Do you have any medical conditions?_____

Do you currently take any prescription or over the counter medications or vitamins/nutritional supplements? Y/N
If yes, specify name and reason for taking: _____
_____
_____

I hereby authorize Taunton Chiropractic and Health Centre, with my prior knowledge, to release or to obtain any health information from my other healthcare providers as my be require for the management of my case.
I have read an understand the Taunton Chiropractic and Health Centre fee schedule and the 24-hour cancellation policy.

Client Signature:_____ Date:_____

Family Health History

Have your grandparents, parents or siblings ever been diagnosed with any of the following?

- ☐ High blood pressure
- ☐ Heart disease
- ☐ Stroke
- ☐ Diabetes (Type I or TypeII)
- ☐ Thyroid / Hormone problems
- ☐ Breathing or lung problems
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Neurological problems
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Other specify:

Client Health History

Please **check anything which is causing you problems right now**

Cardiovascular:

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Congestive heart failure
- ☐ Heart Attack
- ☐ Phlebitis
- ☐ Varicose veins
- ☐ Stroke/TIA
- ☐ Pacemaker/ICD/or similar
- ☐ Heart Disease
- ☐ Aneurysm

Musculoskeletal:

- ☐ Back Ache
- ☐ Swollen Joints

Foot Pain L / R

Shoulder Pain L / R
Elbow Pain L / R
Wrist Pain L / R
Hand Pain L / R

Hip Pain L / R
Knee Pain L / R

- ☐ Arthritis
- ☐ Weakness
- ☐ Loss of Strength

TMJ Problems L / R

Respiratory:

- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Bronchitis/Emphysema
- ☐ Asthma

Head/Neck:

- ☐ Seizures/Epilepsy
- ☐ Deafness
- ☐ Earache
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Loss of Vision
- ☐ Enlarged Glands
- ☐ Speech Problems
- ☐ Headaches
- ☐ Migraines
- ☐ Frequent Colds
- ☐ Sinus Problems

Other:

- ☐ Rashes
- ☐ Itching
- ☐ Bruise Easily
- ☐ Heat Cold intolerance
- ☐ Loss of sensation (where?)
- ☐ Dry Skin
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Tuberculosis (TB)
- ☐ HIV
- ☐ Herpes
- ☐ Other Skin conditions:

Women:

- ☐ Pregnant?

Due:_____

- ☐ Menstrual cramps
- ☐ Hot Flashes
- ☐ Breast pain/lump
- ☐ Other:

_____

Allergies/Hypersensitivities: _____

Type of reaction: _____

Other Health information you want us to know: _____

_____