Tell us about yourself.

We need this information to ensure your safety and health and best possible care. All information you share with us on this form is kept confidential among our staff, yourself and only those specific people you authorize us to share it with.

LEAVE THIS BLANK

TODAY'S DATE

DAY MONTH YEAR

Mr.	Mrs.	Miss	Ms.	Dr.	Name
Home #					Address (include city + postal code)
Work #					
Cell #					
Birth day month year					
Occupation					Email
Whom may we thank for referring you?					

Your health history

Name of previous chiropractor + location
Have you had any X-rays taken of your spine? YES NO
Ladies: date of your last menstrual period
Ladies: any chance of being pregnant? YES NO
Your Family Physician
List the conditions you have been treated for in the last 10 years.

Responsibility for your account

Name of person responsible for your account, if not yourself:	Check if your visit is related to:	Motor Vehicle Accident ☐
		Workers Compensation ☐
Relationship to you:	Do you have extended health coverage? YES NO	
	If so, how much per year for chiropractic care?	

336 Eagle Street North
Unit 1C
Cambridge, Ontario N3H 1C2
(519) 653-1020

blaser
CHIROPRACTIC FOR LIFE

Health of your family

FIRST NAME	AGE	RELATION	HEALTH CONDITIONS

Your healing goals

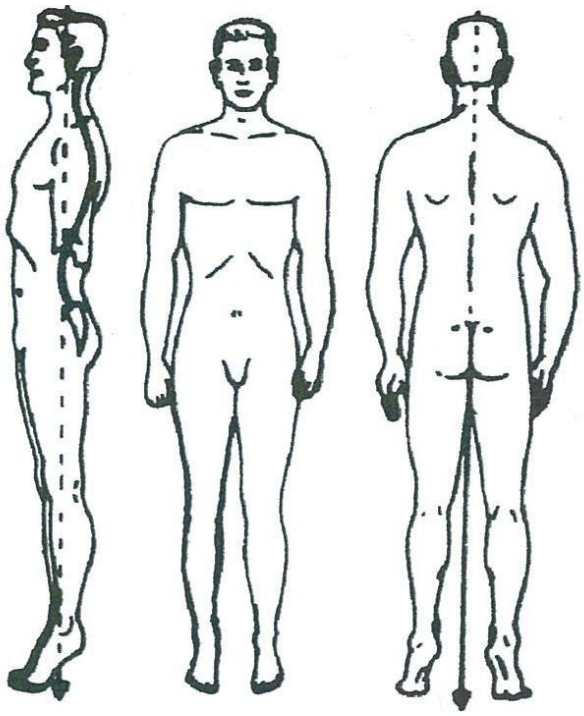
What is your major concern?

How long have you been suffering from this condition?

How is this condition affecting you?

What would you like to achieve through chiropractic care?

Any other concern?



Mark areas of pain or dysfunction

Your signature

By signing below you agree that you have provided an accurate and complete health history and have not knowingly omitted any information. You understand that you will assume responsibility for fees associated with the chiropractic services provided for you.

SIGNATURE of PARENT or GUARDIAN

YOUR SIGNATURE

PRINT NAME of PARENT or GUARDIAN

DATE