



Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Medical Doctor's Name: \_\_\_\_\_ Doctor's Phone Number: \_\_\_\_\_

### Current Health Condition

What brings you in to see us? \_\_\_\_\_

When did it start? \_\_\_\_\_ Have you had a similar problem in the past? \_\_\_\_\_

This condition is:  constant  comes & goes  getting worse

This condition is interfering with:  work  sleep  daily routine  sports

Have you consulted others about this condition?  Yes  No

If so, whom?  General Practitioner  Chiropractor  Massage Therapist  Physiotherapist  Other

How long has it been since you felt good? \_\_\_\_\_

What makes your condition: Worse? \_\_\_\_\_  
Better? \_\_\_\_\_

Please list all major illnesses and surgeries : \_\_\_\_\_

Have you ever been in a car accident? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Do you have any other health complaints? \_\_\_\_\_

If you are pregnant, when is your due date? \_\_\_\_\_

Do you have any environmental allergies?  Yes  No If Yes, please list: \_\_\_\_\_

Do you have any allergies to medications?  Yes  No If Yes, please list: \_\_\_\_\_

Please check any current conditions ("P" is past condition, "C" if current condition)

**CARDIOVASCULAR**

- High blood pressure
- Low blood pressure
- MI (heart attack)
- Phlebitis
- Stroke/CVA
- Angina
- Pacemaker
- Atherosclerosis
- Chronic congestive heart failure

**INFLAMMATORY**

- Rheumatoid Arthritis
- Osteoarthritis
- Lupus
- Reiter's Syndrome
- Scleroderma
- Polymyalgia
- Fibromyalgia
- Ankylosing Spondylitis
- Gout

**RESPIRATORY**

- Chronic Cough
- Bronchitis
- Asthma
- Shortness of Breath
- Emphysema
- Do you smoke?

**HEAD/NECK**

- Ear problems
- Vertigo
- Blurred Vision
- Earaches
- Vision loss
- Sinus problems

**MUSCLE PAIN AND TENSION**

Neck

- right  left
- front  back

Shoulders

- right  left
- front  back

Arm

- right  left
- front  back

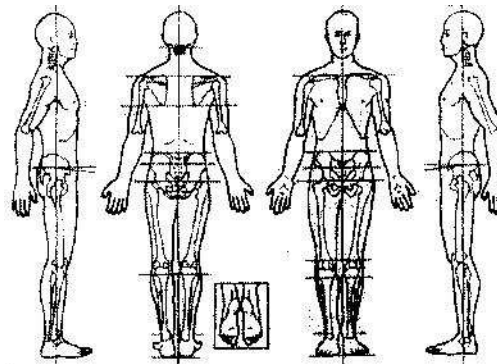
Leg

- right  left
- front  back

Back

- upper  mid
- lower

Please indicate the areas you are experiencing pain or discomfort on the diagrams to the right.



**COMMUNICABLE DISEASES**

- TB
- Hepatitis
- HIV

**SKIN**

- Rash
- Sensitivity
- Eczema
- Bruise easily
- Varicose veins
- Psoriasis

**NERVOUS**

- Loss of Sensation
- Epilepsy
- Multiple Sclerosis
- Buerger's Disease
- Neuralgia
- Neuritis
- Spastic Paralysis
- Flaccid Paralysis

**PELVIC**

- PID
- Endometriosis

**DIGESTIVE**

- Crohn's Disease
- Irritable Bowel Syndrome
- Colitis
- Prolonged Constipation
- Prolonged Diarrhea
- Hiatus Hernia
- Reflux
- Ulcers

**OTHER**

- Cancer
- Diabetes
- Kidney Disease
- Thyroid Disease
- Insomnia
- Migraines
- Headaches
- Nausea
- Jaw Problems
- Fainting/Dizziness
- Hemophilia
- Chronic Fatigue
- Environmental Sensitivities
- Degenerated discs
- Arthritis
- Internal pins/wires
- Artificial joints

I understand and agree that the information I have provided is accurate, current and will be confidential. If at any time there is any change to my health status I will let my Practitioner know as soon as possible.

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Signature: \_\_\_\_\_

Date: \_\_\_\_\_