McAllister Chiropractic and Massage

17 Ontario Street, Oshawa, ON L1G 4Y6 PH: (905) 433-4131 FX: (905) 433-2008

ACUPUNCTURE – Health History Form

WELCOME TO OUR OFFICE – Please complete all requested information. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential, you will be asked to provide written authorization for release of any information.

			Patient Number
First Name	**Surname**		**Date**
Address	**Apt #**	**City**	**Postal Code**
Tel # (home)	**Tel # (work including extension)**		**Tel # (cell)**
Date of Birth (day / month / year)	☐ **Male** ☐ **Female**	**Who referred you to our office?**	
Is this a W.S.I.B. or work related injury? ☐ **No** ☐ **Yes**	**Accident Date**		**W.S.I.B. Claim # (if known)**
Is this a result of a motor vehicle accident? ☐ **No** ☐ **Yes**	**Accident Date**		**S.I.N. (if W.S.I.B. is claimed)**
What is your major complaint?		**Have you had spinal x-rays taken within the last two years?**	
Please describe your symptoms:			
What makes it worse?		**What makes it better?**	
List previous falls, accidents, and injuries: ☐ **None**			
List any illnesses and surgeries: ☐ **None**			
List any medications you are taking: ☐ **None**			
What treatments have you received?			
Have you had acupuncture before?	**When?**	**Why?**	
Is there anything else the doctor should be aware of?		**Females: Do you suffer from PMS/dysmenorrhea?**	

LIST ANY FAMILY MEMBERS WHO SUFFER FROM THE FOLLOWING:

Arthritis	**Cancer**	**High Blood Pressure**	**Heart Disease**
Stroke	**Diabetes**	**Other**	