McAllister Chiropractic and Massage

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

CHIROPRACTIC – 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?**
Have you received chiropractic care before?	**What is your major complaint?**		
How long have you had this condition?			
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)**
Extended Health Care (Company Name)	**Policy #**		**Id or Certification #**
Plan Member's Name	**Plan Member's Birth Date**		**Is there an Alternate Plan?**
List any illnesses and surgeries: ☐ **None**			
List any medications you are taking: ☐ **None**			
Do you require custom foot orthotics?	**For Women Only: Are you pregnant?**		**Date of last menstrual cycle**

HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING? **Please circle any of the following, should they apply:**

Arthritis	**Asthma**	**Backache**	**Diabetes**	**Digestive Disorders**
Dizziness	**Epilepsy**	**Headaches**	**Heart Trouble**	**Neck Pain**
Neuritis	**Sinus**	**Stroke**	**Ulcers**	