McAllister Chiropractic and Massage

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PHYSIOTHERAPY – 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?**
Medical Doctor's Name	**Dr.'s Phone #**
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?	
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 for this condition?	

Do you smoke? ☐ **No** ☐ **Yes**	**# Of Cigarettes per day?**	**When?**	**Why?**

Have you seen another practitioner for this condition? ☐ **No** ☐ **Yes** **Name:**	**Occupation:**
Is there anything else that we should be aware of?	

LIST ANY FAMILY MEMBERS WHO SUFFER FROM THE FOLLOWING:

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