GENERAL CONTACT INFORMATION

Name:_____Date:___/___/___
(Last name) (First name) (Middle name) *dd/mm/yyyy*

Age:_____ Sex: ␣ Female ␣ Male Date of Birth:___/___/___ *dd/mm/yyyy*

Address: _____
(Street/PO box)

_____
(City) (Province/Sate) *(Postal code/Zip)*

_____
(Home number) *(Work)* *(Mobile)*

_____
(Email) *(Fax)*

May we leave messages on your phone line? Y / N Preference: Home / Work / Cell

Occupation:_____
How did you hear about this clinic?_____

Emergency Contact:

_____
(Name)(Relationship)

_____
(Home phone) *(Work)* *(Mobile)*

Primary physician?_____
(Name) *(Telephone)*
Last physical exam?_____
(Month/year)

What is the nature of the acute illness/complaint? Be as specific as possible:

_____
_____
_____
_____
_____

HISTORY OF PRESENT ILLNESS

How did this complaint develop? How long has it been occurring? Have you experienced this before? If due to an accident, please describe what happened in detail

_____
_____
_____
_____
_____

Have you noticed anything in particular that is making the complaint better or worse?

_____

_____

_____

What other treatment have you sought for this complaint? What have the results been?_____

_____

_____

Medications – List all your present medications both for the acute complaint and for chronic health concerns including drugs, vitamins, minerals, homeopathics, herbs and their dosages:

_____

_____

_____

_____

Are you allergic to any medicines or other substances? If yes, please list:

_____

_____

_____

_____

Please mark any problem or painful areas as exactly as possible with an X on the diagram bellow