Health MOMENTUM CENTRE FOR THERAPEUTIC MEDICINE

CLIENT INFORMATION

LAST NAME _____ FIRST NAME _____

ADDRESS _____ CITY _____ POSTAL CODE _____

PHONE *home* _____ *work* _____ *cell* _____ EMAIL _____

DATE OF BIRTH _____ OCCUPATION _____

WHERE DID YOU HEAR ABOUT US? _____

MEDICAL DOCTOR _____ PHONE _____

OTHER HEALTH CARE? ○ chiropractic ○ naturopathic ○ physiotherapy
○ other *please explain* _____

PRESENT COMPLAINT _____

How long have you had this condition? _____

What aggravates this condition? _____

HEALTH HISTORY QUESTIONNAIRE

Please check all current and past conditions.

MUSCLE
○ pain ○ stiffness ○ tear ○ shoulder pain
○ back pain ○ strain ○ whiplash ○ poor posture
○ tendonitis ○ bursitis ○ limitation of movement
○ other *please explain* _____

BONE/JOINT
○ pain ○ sprain ○ dislocation ○ disc degeneration
○ swelling ○ fracture ○ protrusion ○ rheumatoid arthritis
○ prolapse ○ bursitis ○ osteoarthritis ○ TMJ syndrome
○ other *please explain* _____

HEAD
○ headache ○ migraine ○ seizure ○ brain injury
○ concussion ○ earache ○ vertigo ○ ringing in the ears
○ other *please explain* _____

LUNGS/RESPIRATION
○ bronchitis ○ asthma ○ pneumonia ○ chronic recurrent lung infections
○ emphysema ○ allergies ○ sinus infection ○ shortness of breath
○ other *please explain* _____

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HEART/CIRCULATION
O heart attack O stroke O aneurysm O high/low blood pressure
O angina O phlebitis O fatigue O varicose veins
O poor healing O bruise easily O cold hands/feet
O other *please explain* _____

DIGESTION
O ulcers O hiatal hernia O diverticulitis O irritable bowel syndrome
O acid reflux O Crohn's disease
O other *please explain* _____

NERVOUS SYSTEM
O numbness O tingling O sciatica O thoracic outlet syndrome
O other *please explain* _____

ORGAN DISEASE/ CONDITION
O heart O lungs O kidney O liver
O stomach O colon O pancreas O skin
O other *please explain* _____

OTHER DISEASE/ CONDITION
O AIDS O cerebral palsy O epilepsy O multiple sclerosis
O diabetes O fibromyalgia O chronic fatigue syndrome
O other *please explain* _____

SURGICAL OPERATIONS _____

CURRENT MEDICATIONS _____

MAJOR INJURY/ACCIDENT _____

FOR WOMEN ONLY
O hysterectomy O fibroid O menopause O dysmenorrhea
O bladder leak O endometriosis O miscarriage O ectopic pregnancy
O other *please explain* _____
pregnancy due date _____ delivery/labour type _____
complications, if any _____
post-partum problems/pain O no O yes *please explain* _____
birth trauma O no O yes *please explain* _____

CHILDREN/ INFANTS
O dyslexia O ADD/ADHD O colic O learning disabilities
O irritability O poor sleep O slow development of fine/gross motor skills
O other *please explain* _____

EXERCISE
O rehabilitative O competitive O recreational
please explain the program _____

CLIENT'S CONSENT TO TREATMENT

I understand the information given on this form is strictly confidential, and will be released to other health care professionals or legal representatives only with my written consent. I understand that a notice of 48 hours is required to reschedule my appointment or I will be billed the full amount for short notice/missed appointments.

I understand that I have the right to ask questions about my treatment. If at any time I feel uncomfortable, I can ask the therapist to stop or alter the treatment of clarify the reason for the particular technique being used.

DATE _____ CLIENT SIGNATURE _____