Rosemary Heights Clinic

Confidential Patient History Form **File#:_____**

Last Name: _____ First Name: _____Gender___ Male ___Female
Birthday(MDY): _____ Age: _____Weight: _____Care Card #:_____
Address _____City:_____ Province:_____Postal Code: _____
Phone:Home:_____Work:_____Cell:_____Email:_____
Occupation:_____ Employer: _____ Family Doctor: _____
Please indicate who referred you to the office: _____
Is this a ICBC/WCB/DVA case: yes/no (for chiropractic only)
ICBC/WCB/DVA: Claim #: _____ Adjustor Name: _____ Phone:_____

Please Indicate With a (If You Believe if any of the following apply to you (P= Past C=Current)

__Heart Attack	__Headache/Migraines	__Joint Dislocation
__High/Low Blood Pressure	__Dizziness/Fainting	__Bone Fracture
__Stroke /Aneurysm	__Nausea	__Arthritis
__Pace Maker	__Spinal Injury	__Osteoporosis
__Other Heart Conditions	__Head Injury	__Rods/Implants/Plates/Shunts
__Varicose Veins	__Epilepsy	__Implants
__Bruise easily	__Other Neurological Conditions	__Transplants
__Diabetes	__Asthma	__Cancer
__Kidney Disease	__Chronic Sinusitis	__Hepatitis
__Other Urinary Condition	__Bronchitis	__HIV
__Allergies	__Digestive Condition	__Other Contagious Condition
__Fibromyalgia	__Irritable Bowel/Colitis	

Exercise: ___Yes___No Type: _____ Frequency: _____ Recent Changes ___Yes___No
Sleep: Position: ___Side ___Back ___Stomach Mattress Age: _____years Hours per night ___
Work: Usually ___Sitting ___Standing ___Moving
Please List any Medications (prescription/non-prescription) /Vitamins/Supplements you presently take:

_____

Any Changes in Medications/Vitamins/Supplements in the past three months: ___Yes ___No
Do you have any family history of medical conditions? ___Yes ___No
Please List: _____
Please list ANY accidents, illnesses, surgeries or hospitalizations and the year in which they occurred:

Agreement

1. **I understand that my appointment time today and in the future has been reserved for me and that I am required to give 24 hours cancellation notice or a cancellation fee of $25 will be charged**
2. **I understand that payment for all treatment, whether private or insured, is ultimately my responsibility. This includes a service fee of $20 for any returned cheques**

*** Signature: _____ Date: _____**

* To be signed at the office