Annette Davis, RMT

HEALTH HISTORY FORM

Name: **Date of initial visit:**
Address: **Phone number:**
Date of birth: **Referred by:**
Physician's name: **Allergies:**
Sports & activities:

Current medications:

Are you under medical care for any of the following: (circle)

heart conditions	high/low blood pressure	fainting or dizziness
varicose veins	phlebitis/circulatory problems	headaches or migraine
neck injury	back injury	jaw or ear pain
osteoporosis	rheumatoid arthritis	osteoarthritis
cancer	kidney disease	skin conditions
diabetes	asthma/respiratory	fibromyalgia
Crohn's disease	pelvic inflammatory disease	epilepsy
nervous disorders	whiplash	other:

Have you received care from any of the following: (circle)

physiotherapist	chiropractor	massage therapist
naturopath	other:	

Reason for treatment: **Number/duration of treatments:**

Have you had surgery in the past? If yes, for what?

Have you had any fractures/sprains in the past? If yes, where?

Have you had any serious illnesses in the past? If yes, for what?

Did the current injury result from a motor vehicle accident or workplace injury?

Have you had any of the following regarding your current condition: (circle)

Physician's examination x-ray other diagnostic tests

What relieves your pain? **What aggravates your pain?**

Signature of Patient or Guardian: _____