Dr. Cameron Edgar
Dr. Maja Edgar

EDGAR
Family Chiropractic

**PATIENT INTRODUCTION**
***(PLEASE PRINT)***

Name: _____ _____ Gender: Male□ Female□
First Last

Date of Birth: (Year) _____ (Month) _____ (Day) _____

Home Address: _____

City_____ Province: _____ Postal Code_____

Home Telephone: ( ) _____Cell Number: ( ) _____

Work Telephone: ( ) _____ Email: _____

I would like to be added to the clinic email list for important clinic notices and one monthly newsletter: YES NO

Family Dr.: _____ Phone Number: ( ) _____

**REFERRED BY: _____**

**MVA**

Is this a result of a Car Accident? Yes □ No □

**Date of Accident**: (Year) _____ (Month) _____ (Day) _____

Name of Auto Insurance: _____

Policy Holder's Name: _____

Policy Number: _____ Claim No.: _____

Have you been to any other Rehab Clinic: Yes □ No □

If yes, date of first and last Visit: _____

**INSURANCE COVERAGE (EXTENDED HEALTH CARE)**

Do you or your spouse or guardian have Extended Health Care coverage? Yes □ No □

Name of the Insurance Company: _____

Policy Holder's Name: _____

Relationship to Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy or Plan#: _____Group ID#: _____

Cert. #: _____

**WSIB**

Is this a result of a Work Accident? Yes □ No □

Employer's Name: _____ Tel Number: _____

WSIB Claim Number: _____ **Date of Accident**_____

399 Pearl Street Burlington, ON L7R 2M8
Tel: 289-337-1202 Fax: 289-245-1482

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# HEALTH HISTORY FORM

For your information :
An accurate health history is important to ensure that it is safe for you to receive therapy treatment.

Name: _____Date _____

What are your reasons for seeking treatment?

1. _____
2. _____
3. _____

Please check or fill in the appropriate information

**Head/Neck**
- ☐ **headaches**
- ☐ **migraines**
- ☐ **sinus problems**
- ☐ **ear problems**
- ☐ **vision problems**
- ☐ **vision loss**
- ☐ **contact lenses**
- ☐ **glasses**
- ☐ **hearing loss**

**Cardiovascular**
- ☐ **high blood pressure**
- ☐ **low blood pressure**
- ☐ **CCHF**
- ☐ **heart disease**
- ☐ **heart attack**
- ☐ **stroke /CVA**
- ☐ **poor circulation**
- ☐ **varicose veins**
- ☐ **pacemaker or similar device**

**Respiratory**
- ☐ **chronic cough**
- ☐ **shortness of breath**
- ☐ **smoke _____**
- ☐ **asthma**

**Muscles / Joints**
- ☐ **neck _____**
- ☐ **low back _____**
- ☐ **mid back _____**
- ☐ **upper back _____**
- ☐ **shoulders _____**
- ☐ **arm L/R _____**
- ☐ **leg L/R _____**
- ☐ **knee L/R _____**
- ☐ **other _____**

**Digestive/Uro-genital**
- ☐ **difficult digestion**
- ☐ **constipation**
- ☐ **liver / gall bladder**
- ☐ **kidney / bladder**

**Other Conditions**
- ☐ **loss of sensation**
- ☐ **diabetes (onset: _____)**
- ☐ **epilepsy**
- ☐ **allergies _____**
- ☐ **insomnia**
- ☐ **cancer _____**
- ☐ **arthritis _____**
- ☐ **hepatitis _____**

**Infections**
- ☐ **Hepatitis**
- ☐ **Skin conditions**
- ☐ **TB**
- ☐ **HIV**

**Woman**
- ☐ **Pregnant (Due: _____)**

**What is your general health status?**

_____
_____

Current Medications: _____
Condition it treats: _____
Surgery: _____ Date: _____
Nature: _____
Injury: _____ Date: _____
Nature: _____

Primary Care Physician: _____
Address: _____
Present Involvement in Other Health Care: Yes No
If yes, please specify: _____
_____
_____

Other Medical Conditions (eg: digestive conditions, gynaecological conditions, hemophilia, etc): _____
_____

Of Special Note (presence of internal pins, wires, artificial joints, special equipment): _____
_____