Movement Chiropractic

7-3602 Taylor Street East
Saskatoon, SK S7H 5H9

ACUPUNCTURE CONFIDENTIAL PATIENT HISTORY

NAME:_____ DATE:_____

ADDRESS:_____ CITY/TOWN:_____

PROV. _____ POSTAL CODE:_____ PHONE: _____CELL:_____

BIRTHDATE: DD/_____MM/_____YY/_____AGE: _____

EMAIL:_____Email Appointment Reminders? □ Yes □ No

OCCUPATION:_____HOW DID YOU HEAR ABOUT OUR CLINIC □Google □Friend/Family □Website

Main reason for consulting the clinic:_____

_____

_____

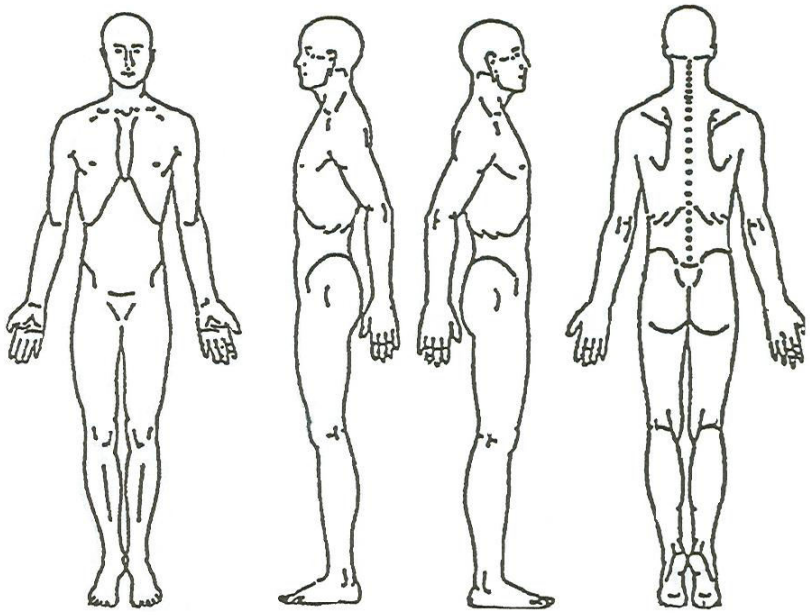
Past Acupuncturist:_____ Last Visit:_____

Medical Doctor:_____ Last Visit:_____

Please advise us of health conditions affecting you in the ***Present***, in the ***Past***, or in your immediate ***Family*** (parents, grandparents, siblings, children).

Condition	Present	Past	Family	Condition	Present	Past	Family
Arthritis				High Cholesterol			
Asthma				High Blood Pressure			
Cancer				Multiple Sclerosis			
Concussion				Osteoporosis			
Diabetes				Seizures			
Headaches				Stroke/Aneurysm			
Cardiovascular Disease				Transient Ischemic Attack			

Please use the diagram to indicate areas of pain, stiffness, numbness, tingling, aching, etc.



Do you take any MEDICATIONS? □ If so, please list:_____

_____

Have you suffered TRAUMA? □ If so, please describe:_____

_____

Have you had significant SURGERY? □ If so, please describe:_____

_____

Are you PREGNANT? □ No □ Yes Due Date:_____

Do you have ALLERGIES? (food, drugs, pollen, etc.) □ If so, what to?_____

Are you a SMOKER? □ No □ Yes (Packs/day x Years)_____ □ Quit Date:_____

Is there anything else that you think I should know?_____

_____

This information contained on this form is true to the best of my knowledge.

Patient Signature:_____ Date:_____