Dr. Stephanie Harrison, DC & Dr. Ronald J. McGarrie, DC
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CONFIDENTIAL PATIENT HISTORY

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Today's Date: _____

Full Name: _____ Birthdate (d/m/yr) : _____ Age: _____

Marital Status: S M Sep Div W ComLaw # of Children: ____ Emergency Contact & #: _____

Address: _____ City: _____Postal Code: _____

Home #: _____ Cell #: _____

Work #: _____ Ext: _____ **Email:** _____ **(For Office Use only)**
(By agreeing to provide your email address, this message is intended only for use within our office and will not be used for distribution to any marketing companies).

Occupation: _____ Employer: _____

Who Referred you to our Clinic? _____

Is this a result of a Motor Vehicle Accident (MVA)? YES _____ NO _____

Is this a possible Worker's Compensation case (WSIB)? YES, injured at work _____ NO _____

Have you been investigated for, or diagnosed with any of the following conditions? Please check.

_____Asthma	_____Gout	_____Osteoporosis
_____Bronchitis	_____Heart Disease	_____Prostate Disease
_____ Bladder Infections	_____Hernia (femoral, inguinal)	_____Phlebitis
_____Cancer	_____Hiatal Hernia	_____Rheumatoid Arthritis
_____Diabetes	_____High Blood Pressure	_____Skin Conditions
_____Disc Herniation	_____Kidney Stones/Disease	_____Stroke
_____Epilepsy	_____Meningitis	_____Thyroid Problems
_____Fainting	_____Migraines	_____Ulcer
_____Gall Bladder Disease/Stones	_____Osteoarthritis	_____Urinary Tract Infections

Please complete the Health Information on the reverse side.

DURHAM
SPORT AND WELLNESS

HEALTH INFORMATION

What is your major complaint?: _____

Have you had this condition in the past or anything similar? Yes_____No_____

If yes, when? _____

Is the condition becoming worse? Yes _____ No _____ Constant _____ Varies _____

Is the condition interfering with your: Work _____ Sleep _____ Daily routine _____ Other_____

What aggravates the condition?: _____

What relieves the condition: Ice _____ Heat _____ Other _____ Medication _____

Medication you now take?: _____

Have you ever been involved in a Motor Vehicle Accident (MVA): Yes ___ No ___ Date(s): _____

Have you had a fall recently? Yes _____ No _____

List all previous surgical procedures: _____

Have you had previous chiropractic care? Yes _____ No _____ With whom? _____

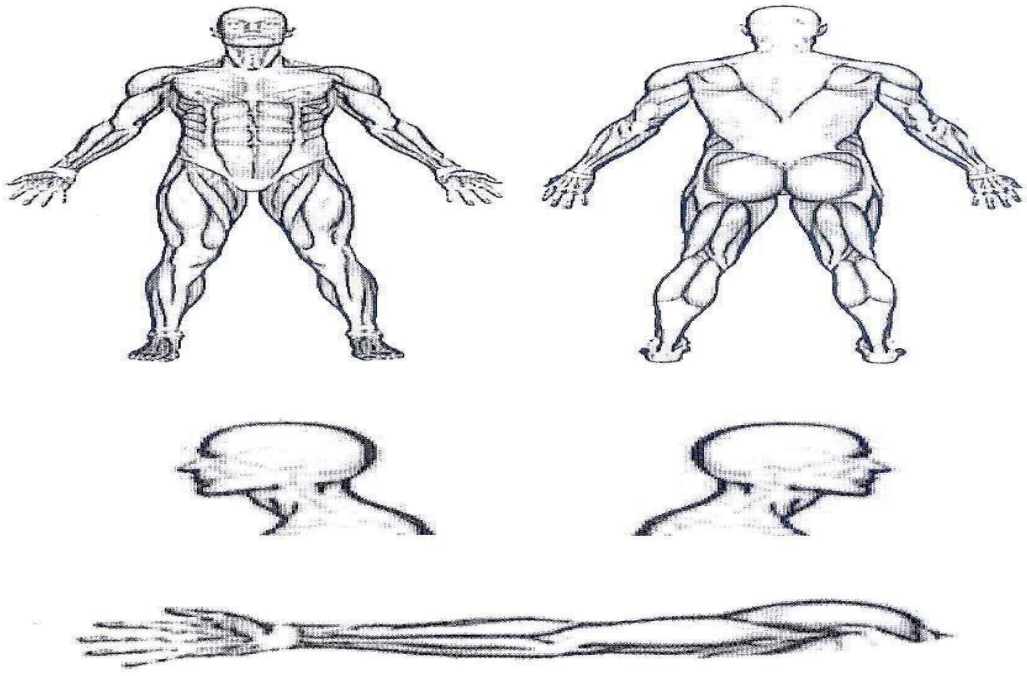
Where? _____ When? _____ For what reason? _____

Have you had recent X-rays (past 3 years) of your problem area(s)? Yes _____ No _____

Date of last physical examination: _____ Doctor's name: _____

Using the symbols indicated in the legend, mark your areas of pain on the figures below. Also please indicate the location of any scars on your body.

LEGEND X = Pain / O = Numbness / -- = Radiations / +++ = Scars



Patient's Signature (or signature of Parent/Guardian as appropriate): _____

Parent/Guardian Name: _____

(if this visit is for a child 16 or younger)