**MASON HEALTH CENTRE**

 **Dr. Michael Hamilton D.C**

 **1070 Main Street West**

  **Hamilton, Ontario**

 **L8S 1B3**

 **905-523-5010**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT DO YOU PREFER TO BE CALLED? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PROVINCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POSTAL CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL DOCTOR & PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STUDENT YES \_\_\_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_\_

HOME NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BUSINESS NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOBILE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHOM MAY WE THANK FOR REFERING YOU? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESPONSIBLE PARTY (*PLEASE COMPLETE IF DIFERENT FROM ABOVE*)

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION

NAME OF INSURED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GROUP/INDIVIDUAL POLICY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CERTIFICATE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE? YES \_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_

(*PLEASE COMPLETE IF DIFERENT FROM ABOVE)*

NAME OF INSURED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GROUP/INDIVIDUAL POLICY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CERTIFICATE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH HISTORY

PURPOSE OF APPOINTMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHEN DID THIS CONDITION BEGIN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF DISABLED FROM WORK, PLEASE GIVE DATES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THE INJURY JOB RELATED \_\_\_\_\_\_\_\_ AUTO RELATED \_\_\_\_\_\_\_\_ DATE OF ACCIDENT/INJURY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAJOR SUGERY/OPERATIONS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAJOR ACCIDENTS/FALLS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES \_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_ LAST VISIT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU HAD PREVIOUS MASSAGE THERAPY? YES\_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_ LAST VISIT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU CURRENTY BEING TREATED FOR A HEALTH CONDITION? YES \_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

PLEASE EXPLAIN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING?

\_\_\_\_\_\_ RHEUMATIC HEART DISEASE OR RUMATIC FEVER \_\_\_\_\_\_ LUNG OR BREATHING PROBLEMS

\_\_\_\_\_\_ HEART DEFECT OR HEART MURMUR \_\_\_\_\_\_ ASTHMA OR HAY FEVER

\_\_\_\_\_\_ HEART TROUBLE, HEART ATTACK OR ANGINA \_\_\_\_\_\_ STROKE

\_\_\_\_\_\_ HEART SURGERY \_\_\_\_\_\_ FAINTING OR DIZZY SPELLS

\_\_\_\_\_\_ CONGENTIAL HEART PROBLEM \_\_\_\_\_\_ DIABETES

\_\_\_\_\_\_ CHEST PAIN \_\_\_\_\_\_ AIDS OR HIV INFECTION

\_\_\_\_\_\_ SHORTNESS OF BREATH \_\_\_\_\_\_ THYROID PROBLEMS

\_\_\_\_\_\_ PACEMAKER \_\_\_\_\_\_ ARTHRITIS OR RHEUMATISM

\_\_\_\_\_\_ HIGH/LOW BLOOD PRESSURE \_\_\_\_\_\_ JOINT REPLACEMENT

\_\_\_\_\_\_ SWELLING OF FEET OR ANKLES, HANDS \_\_\_\_\_\_ CHEMOTHERAPY (CANCER, LEUKEMIA)

\_\_\_\_\_\_ HEPATITIS, JAUNDICE OR LIVER DISEASE \_\_\_\_\_\_ EPILEPSY OR SEIZURES -\_\_\_\_\_\_ CHEMICAL DEPENDANCY \_\_\_\_\_\_ HYPOGLYCEMIA

\_\_\_\_\_\_ NERVOUSNESS \_\_\_\_\_\_ ANEMIA

\_\_\_\_\_\_ MENTAL HEALTH CARE \_\_\_\_\_\_ EATING DISORDERS

WOMAN ONLY

ARE YOU PREGNANT OR YOU THINK YOU MAY BE PREGNANT? YES\_\_\_\_\_\_\_\_\_ # OF WEEKS \_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_

WHEN WAS YOUR LAST PERIOD? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST 6 MONTHS

\_\_\_\_\_ LOW BACK PAIN \_\_\_\_\_\_ FORGETFULNESS

\_\_\_\_\_\_ NECK PAIN \_\_\_\_\_\_ CONFUSION/DEPRESSION

\_\_\_\_\_\_ ARM PAIN \_\_\_\_\_\_ COVULSIONS

\_\_\_\_\_\_ LEG PAIN \_\_\_\_\_\_ COLD/TINGLING EXTREMITIES

\_\_\_\_\_\_ PAIN BETWEEN SHOULDERS \_\_\_\_\_\_ DIFFICULT CHEWING/CLICKING JAW

\_\_\_\_\_\_ HEADACHES \_\_\_\_\_\_ STRESS

\_\_\_\_\_\_ JOINT PAIN/STIFFNESS \_\_\_\_\_\_ FATIGUE

\_\_\_\_\_\_ WALKING PROBLEMS \_\_\_\_\_\_ ALLERGIES

\_\_\_\_\_\_ NUMBNESS \_\_\_\_\_\_ LOSS OF SLEEP

\_\_\_\_\_\_ PARALYSIS \_\_\_\_\_\_ FEVER

\_\_\_\_\_\_ DIZZINESS \_\_\_\_\_\_ HEADACHES

\_\_\_\_\_\_ JAW PAIN \_\_\_\_\_\_ HEARTBURN

\_\_\_\_\_\_ DIFFICULT CHEWING/CLICKING JAW \_\_\_\_\_\_ VARICOSE VEINS

AUTHORIZATION

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATLEY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

**SIGNATURE OF PATIENT OR PARENT IF MINOR (*Under 16 Years of age*)**

NAME (Please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_