Montgomery
Chiropractic
Plus

CLIENT HEALTH HISTORY

Name: ____ Date:______________________

Address: ____ City: ______________________

Postal Code: _______________ Phone (home): _______________ (cell): _____________________

Date of Birth: ______________ Occupation: _________________ Referred by: ________________

E-MAIL:____

Do we have your **consent** to e-mail you Newsletters or other communication? YES_________NO________

Physician's name: ____

Medications using: ____

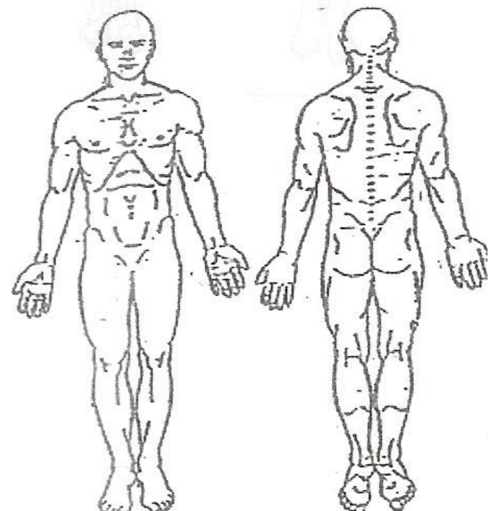
List physical activities you do on a regular basis: ____

____

Please check any of the following conditions you are experiencing:

___ arthritis	___ heart trouble	___ pregnancy
___ back pain	___ high/low blood pressure	___ sciatica
___ bursitis	___ jaw pain	___ sprains/strains
___ cancer	___ joint dysfunction	___ stress
___ cold or flu	___ migraines	___ tendonitis
___ diabetes	___ muscle tension	___ tingling/numbness
___ fibromyalgia	___ muscle pain	___ varicose veins
___ headaches	___ neck pain	___ whiplash
___ broken/fractured bone	___ metal plates/pins	

Rate painful areas of injury, pain or discomfort shade area(s) on the figures below. Rate painful areas, where 5 is the most painful.



Date of injury and/or onset of pain: ______________________________

What caused it? ____

____

What relieves it? ____

____

Other therapies or treatment you are receiving or received for this condition:

____

____

CANCELLATION POLICY

If you are unable to provide us with 24 hours notice on cancelled appointments, there will be a charge for the full price of the appointment.

Signature: Date: