

# CrossFit Squamish/Squamish Barbell Chiropractic Health History

Date: \_\_\_\_\_

*Complete if information is not online*

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Birth Date: (mm/dd/yy) \_\_\_\_\_

PHN: \_\_\_\_\_

How did you find us?

CFS Client  Website  Family/Friend

Other \_\_\_\_\_

Medical Dr. \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

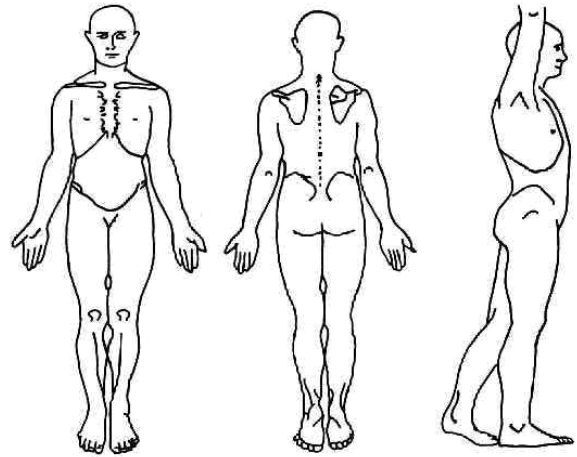
Occupation: \_\_\_\_\_

Email: \_\_\_\_\_

\*What is your primary concern?

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

\*Indicate the location of your symptoms



\*When did you first notice your present symptoms?

\_\_\_\_\_

\*Is it a result of a:

Car Accident? \_\_\_ Work Accident? \_\_\_

Sports Injury? \_\_\_ Other? \_\_\_

\*Have you experienced this before? \_\_\_\_\_

\*Have you had any previous care or seen any other provider(s) for this problem? \_\_\_\_\_

\_\_\_\_\_

\*What are you doing for it now and is it helping \_\_\_\_\_

\_\_\_\_\_

\*Have you noticed any change in your daily activities due to this problem or pain? \_\_\_\_\_

\_\_\_\_\_

***Please continue on the next page...***

\*Is your symptom: Continuous?\_\_\_ On & Off?\_\_\_ Getting worse?\_\_\_ Getting better?\_\_\_\_\_

\* What Aggravates it?\_\_\_\_\_

\_\_\_\_\_

\* What Relieves it?\_\_\_\_\_

\_\_\_\_\_

\*Are there any "associated" problems? (e.g., headaches, dizziness, visual disturbances, ringing-in-ears, loss of breath, swelling, nausea, sweating, heart palpitations, weakness, bowel problems, menstrual changes, arm/leg pain, etc.)\_\_\_\_\_

\_\_\_\_\_

\*List any medications you are currently taking. \_\_\_\_\_

\_\_\_\_\_

*List major Illnesses/Surgeries/Accidents	Date
---	------

_____	_____
-------	-------

_____	_____
-------	-------

_____	_____
-------	-------

*List any past or current medical concerns	
--	--

_____	_____
-------	-------

_____	_____
-------	-------