Cardio-Go Health Centre

Confidential Health Profile

PLEASE FILL IN THIS FORM ON THE FRONT AND BACK. CHECK THE BOXES THAT APPLY TO YOU. All information will be held in strict confidence.

Date: _____ Name: _____

Address: _____ City: _____ Postal Code: _____

Phone (H):_____ (B):_____ (C):_____ Email: _____

Date of Birth:_____ Age:_____ Height: _____Weight: _____

Extended Health Insurance (name of company): _____ Occupation: _____

For WSIB Claims only: OHIP No._____ WSIB Claim No._____

Emergency Contact Name:_____ Emergency Contact #: _____

What brings you in to the clinic today? _____

How did you hear about us? _____ Referred by: _____

MEDICAL:

Medical Doctor: _____ Address: _____ Phone: _____

Alternative Therapies: □ Physiotherapy □ Chiropractic □ Naturopathy Other: _____

CARDIOVASCULAR:

High/Low Blood Pressure □
Heart Attack/Disease □
Varicose Veins □
Stroke □
Other_____

SKIN:

Allergy to oil/lotion □
Sensitivity □
Bruise Easily □
Contagious Condition □
Plantar Warts □

HEAD/NECK:

Vision Problems □
Hearing Loss □
Headaches □
Migraines □

RESPIRATORY:

Asthma □
Chronic Cough □
Shortness of Breath □
Bronchitis □
Smoking/Duration □
Other Lung Disorders:_____

OTHER CONDITIONS:

Sinus □
Allergies □
Cancer_____
Arthritis_____
Blood Conditions_____
(ex. HIV, Hepatitis, Hemophilia)

MUSCLE/JOINT PAIN:

Neck □
Shoulders □
Back-Upper, Mid, Lower □
Legs: Left/Right □
Knees: Left/Right □
Other:_____

DIGESTIVE:

Difficult Digestion □
Constipation □
Diarrhea □
Liver/Gall Bladder □
Kidney/Bladder □

WOMEN:

Menstrual Problems_____
Menopausal Problems_____
Surgery_____
Pregnant/Due Date_____
Other_____

ACCIDENTS/INJURY/SURGERY:

Type Approx. Date

_____
_____
_____

MEDICATIONS:
Current Medications/ Condition it treats: _____
LIFE STYLE:
Sleep: Hrs. /Night _____ Quality? _____ Sleeping Position: _____

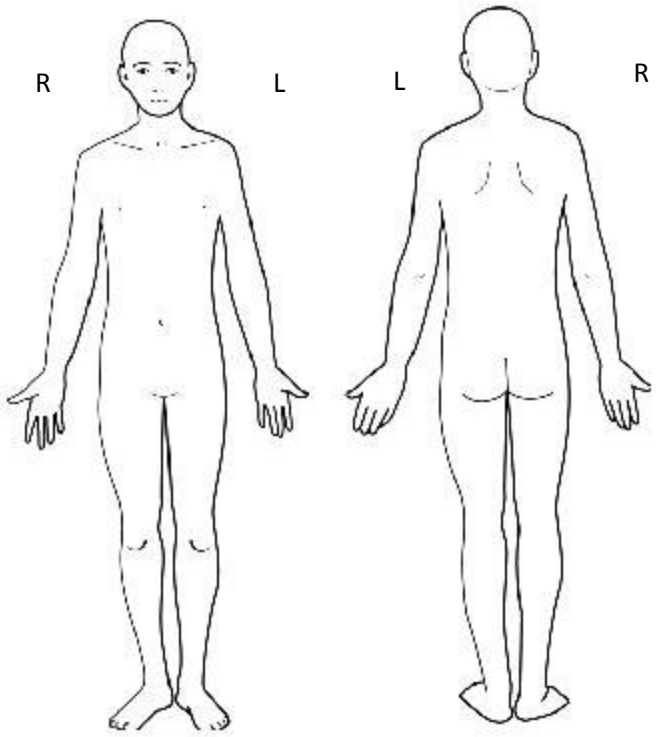
EXERCISE ACTIVITY:	**Type**	**Duration**	**Times Per Week**
	_____	_____	_____
	_____	_____	_____

Any condition, disease, stress factor or prosthesis not mentioned above _____
_____

SYMPTOM DIAGRAM

In the diagram below, please mark the areas on your body that you feel best represent the pain or sensation you are experiencing. Please include ALL areas. Use the symbols provided below.

Numbness	=====	Pins & Needles	::::::::::
Burning	XXXXX	Stabbing & Sharp	///////
Dull & Aching	+++++	Stiff & Tight	*****



Patients Initials_____