CLIENT HEALTH RECORD

NAME:___________________________________ DATE OF BIRTH: ______________________

ADDRESS: ________________________________ CITY/PROVINCE: ______________________

EMAIL: ______________________________ SUBSCRIBE TO SHINE CLIENT LIST: YES NO

TELEPHONE #: ____________________________ REFERRAL SOURCE: ____________________

ARE YOU CURRENTLY UNDERGOING TREATMENTS BY OTHER HEALTH PROFESSIONALS?

CHIROPRACTOR: _____ HOMEOPATH: _____ PHYSIOTHERAPIST: ______ OTHER: ___________

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING SUPPLEMENTS:

DO YOU HAVE ANY ALLERGIES? YES NO IF YES, PLEASE SPECIFY: _______________________

PLEASE INDICATE ANY SORE REGION OF THE BODY: ____________________________________

PLEASE CHECK ALL PAST AND CURRENT CONDITIONS:

CARDIOVASCULAR:	RESPIRATORY:	MUSCLES & JOINTS:
___HEART PROBLEMS	___EMPHYSEMA	___ ARTHRITIS
___HIGH BLOOD PRESSURE	___ASTHMA	___ OSTEOPOROSIS
___LOW BLOOD PRESSURE	___CHRONIC COUGH	___ SOFT TISSUE INJURIES
___ CIRCULATORY PROBLEMS	___BRONCHITIS	___ BACK ACHE (UPPER)
___ VARICOSE VEINS	___ DIFFICULTY BREATHING	___ BACK ACHE (LOWER)
___ STROKE	___ SINUS CONGESTION	___FRACTURE/DISLOCATION

DIGESTION:	WOMEN:	OTHERS:
___ CONSTIPATION	___ IRREGULAR CYCLE	___ DIABETES
___DIARRHEA	___ PMS	___ EPILEPSY
___ ULCER	___ MENOPAUSAL	___ CANCER
___ ABDOMINAL PAIN	___ PREGNANCY	___ THYROID CONDITION
___ NAUSEA/VOMITING	___ ENDOMETRIOSIS	___ MULTIPLE SCLEROSIS

THE INFORMATION GIVEN ABOVE IS CORRECT AND WILL BE KEPT FULLY CONFIDENTIAL AND PRIVATE. I HEREBY CONSENT TO THE TREATMENT AS IT HAS BEEN EXPLAINED TO ME AND GIVE MY PERMISSION TO PROCEED.

SIGNATURE: DATE: