Patient Health History Form

Name: _____ Date: ____/____/____
(Please print clearly) Day Mth Yr

Address: _____ Apt No: _____

City: _____ Province: _____ Postal Code: _____

Cell Phone: _____ Home: _____ Occupation: _____

Email Address (for appointment reminders only): _____

DOB: ___/___/___ Gender: M F Family/Referring Doctor_____
Day Mth Yr

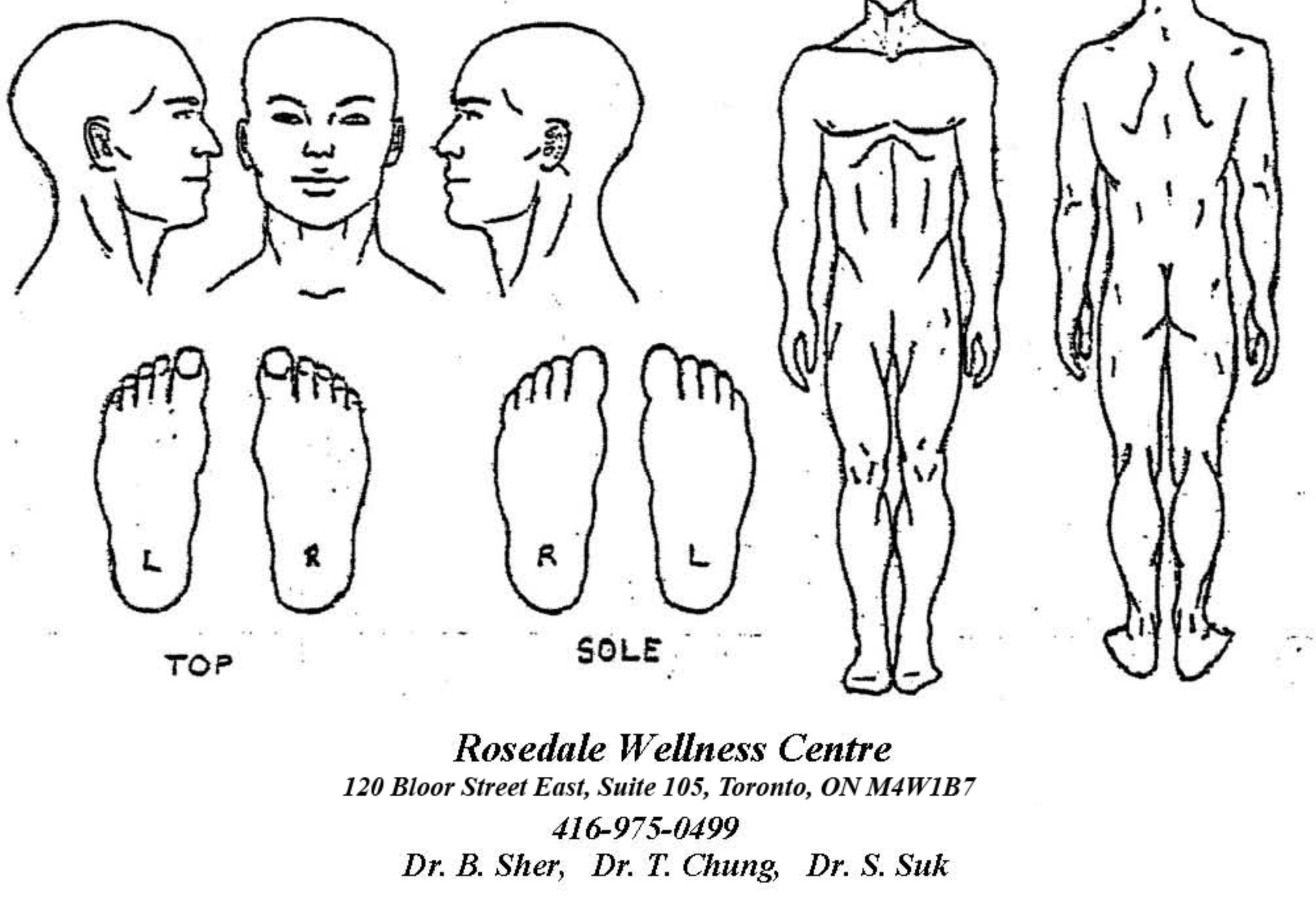
How did you hear about our clinic? _____

Please mark on this line with an "X" the level of pain you are presently experiencing:

Absolutley pain free 0 1 2 3 4 5 6 7 8 9 10 Worst pain of your life

Mark on the diagram where you may be feeling any of the listed sensations:

+++ Aching
*** Numbness
~~~ Pins & Needles
/// Burning
ooo Stabbing
xxx Other



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Dr. B. Sher, Dr. T. Chung, Dr. S. Suk
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