

## Pre-Treatment Information Form

Name:	Date:	
Address:		
City:	Province:	Postal Code:
Tel: (Home)		Tel: (Business)
Email:		Referred By:
Occupation:		Physician:
Date of Birth (D/M/Y):		
Medications (currently administered):		
Primary Reason for Appointment:		

Please answer the following questions by circling the appropriate answer.

▪ Heart problems?	Yes	No
▪ High/Low blood pressure?	Yes	No
▪ Varicose veins?	Yes	No
▪ Blood clotting disorders?	Yes	No
▪ Cancer?	Yes	No
▪ Arthritis?	Yes	No
▪ Sexually transmitted disease (STD or HIV)	Yes	No
▪ Diabetes?	Yes	No
Do you faint easily?	Yes	No
Do you have frequent headaches?	Yes	No
Do you have a cardiac pacemaker?	Yes	No
Do you have any spinal problems?	Yes	No
Have you ever had surgery?	Yes	No
Do you wear contact lenses or dentures?	Yes	No
Do you have any history of Allergic reactions or Asthma?	Yes	No
Females only: Are you pregnant?	Yes	No

**Briefly explain the "Yes" answers:**

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**Do you have any other medical condition of which I should be aware? If so, please specify:**

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