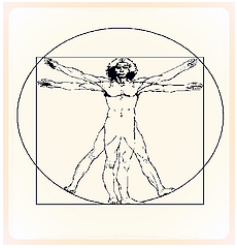

HEALING HANDS CHIROPRACTIC and MASSAGE CLINIC

HEALTH QUESTIONAIRE

Name: _____ Date: _____

1. List your main problems, in order of importance and how long you have had each problem.

_____

_____

_____

2. Have you had any other therapies for these problems? If so, please list and how long you had been having the therapies.

_____

_____

3. Have you had any Accidents or falls? Please list and when they happened.

_____

_____

4. Have you had any surgeries? Please list. _____

_____

5. Are you presently on any Medication? Please list. _____

_____

6. Have you had Chiropractic before?_____
7. Have you had any x-rays? If so, please list the area and the dates they were taken.

_____

_____

8. Is this a motor vehicle accident or work related case? _____

9. Do you suffer from:

a. Tired, aching, fatigued legs	Yes	No
b. Swollen feet, ankles and legs	Yes	No
c. History of varicose veins	Yes	No
d. Are you an expectant mother	Yes	No
e. Family history of venous leg disorders	Yes	No

<u>ICBC and WCB patients ONLY</u>:

I _____ hereby authorize the release to I.C.B.C., or W.C.B. any medical information or records relating to injuries as a result of an accident on _____day of _____ month, 20____.

_____ _____

Signature Date