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New Patient Registration

Patient Information

Name: **Age:** **Occupation:**

Reason for your visit?

Duration of symptoms?

What treatments have you tried to date?

Medications	Bracing/orthotics
Injections	Physiotherapy/Chiropractic

Medical History

Allergies (Please list)**:**

Smoker? (Y/N): **If yes, how long?**

Alcoholic beverages per week?

Recreational Drug Use?

Have you been treated or diagnosed with any of the following conditions?

High blood pressure	**Pacemaker**	**Liver disease**	**Sickle Cell**
Diabetes	Sleep Apnea	Bleeding disorder	Seizures
Heart attack	Asthma	Stroke	Rheumatoid arthritis
Heart failure	Chronic bronchitis/COPD	Transient ischemic attack (TIA)	Hepatitis B/C
Irregular heartbeat	Kidney disease	Blood clots (DVT/PE)	HIV/AIDS

Please list any other medical problems:

Please list any medications you are taking:

Surgical History

Do you or any family members have malignant hyperthermia?

Please list any surgeries you have had in the past: