

Section A: Personal History

Name: _____ Today's Date: _____
Address: _____ City: _____ Prov: _____ Postal: _____
Home Phone: _____ Work Phone: _____
Cellular Phone: _____ Birth Date: Yr _____ mm _____ day _____ age _____
Weight: /Height _____ Occupation: _____
Number of Children ___(Women) _____ Pregnancies: _____ Miscarriages: _____
Marital Status: _____ Referred to office by: _____
Do you have extended health benefits: yes _____ no _____
Are you here because of an injury from car or work related accident: yes _____ no _____
Please give dates of missed work due to the accident or injury: _____
Date of accident/injury: _____ Work related Injury _____ or Car Accident _____

Section B: Current Health Condition

Purpose of this appointment: _____
Major Complaint: _____
Other Doctors seen for this condition: _____
When did this condition begin? _____
Are there others in your family with the same condition? _____
Please list your medications: _____
Do you suffer from any conditions other than that for which you are now consulting us?

Section C: Past Health History

List any major operations: _____
List any major accidents/falls: _____
Hospitalization (other than above): _____
Doctor's name and approximate date of last Visit: _____
Have you been treated for any major health condition in the last year: yes _____ no _____
If yes, please explain: _____
Does anyone else in your family have the same or similar conditions: _____

Check any of the following that you have had.

- Pneumonia Small Pox Influenza Mumps Hepatitis Rheumatic Fever
- Pleurisy HIV/AIDS Polio Chicken Pox Arthritis Epilepsy Eczema
- Tuberculosis Diabetes Cancer Anemia Lumbago Measles Thyroid
- heart Disease Whooping cough Mental Disorder

Daily

Intake: Coffee _____ Tea _____ Alcohol _____ Cigarettes _____ White Sugar _____

Check any of the following you have had in the past six months:

Muscular skeletal code

Gastro-Intestinal Code

C-V-R Code

- Low Back Pain
- Pain shoulders
- Neck pain
- Arm pain
- Joint pain/stiffness
- Walking problems
- Difficulty chewing
- Jaw issues
- Gall bladder issues
- Abdominal cramps

- Poor/excessive appetite
- Excessive thirst
- Frequent thirst
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver problems
- Weight problems
- Gas/bloating
- Heartburn
- Black/bloody stool
- Colitis

- Chest Pain
- Short breath
- Irregular heart beat
- Heart problems
- Lung problems/congestion
- Varicose veins
- Ankle swelling
- Stroke
- Chest pain

Nervous System Code

Genito-Urinary Code

Male/Female Code

- Nervousness
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confused/depression

- Bladder Trouble
- Painful/excessive urination
- Discolored urine

- Menstrual irregularity
- Menstrual cramping
- Vaginal pain/infections
- Breast pain/lumps
- Prostate /sexual dysfunction
- Genital herpes

General Code

EENT Code

Female

- Fatigue
- Loss of sleep
- Allergies
- Fever
- Headaches
- Stuffed nose

- Vision problems
- Dental problems
- Sore throat
- Earaches
- Hearing difficulty

Are you pregnant yes _____ or no _____

Habits Heavy Moderate light None

Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

Do you currently take vitamins or minerals? _____

Do you think you may need to take vitamins or minerals? _____

FEES: Initial Appointment	\$140.00
20 min Sub Appointment	\$70.00
40 Min Sub Appointment	\$140.00
Neural Therapy	\$100.80
Prolo Therapy 5 cc	\$134.40
Prolo Therapy 10cc	\$179.20
Immune Boosting Shot	\$28.00
Vitamin B Shot	\$28.00

*all remedies/supplements are additional

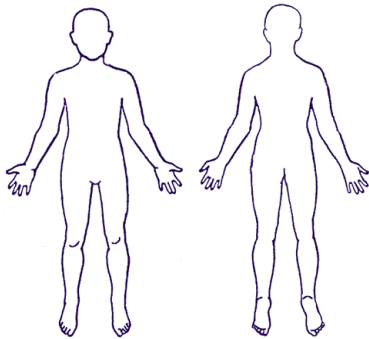
Your appointment time is reserved for you. If unable to keep your appointment, please notify us 24 hours in advance. Failure to do so will result in a missed appointment charge.

***Requirement of a credit card on file for all missed appointments, please see receptionist.**

Fees are payable **at time** of scheduled appointment for all services rendered.

Patient or Guardians signature: _____

Date: _____



Doctor's Signature _____
Dr. Jamie Gallant, ND