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

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

Gastro-Intestinal Code

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

C-V-R Code

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

Nervous System Code

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

Genito-Urinary Code

—Bladder Trouble
—Painful/excessive urination
—Discolored urine

Male/Female Code

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

General Code

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

EENT Code

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

Female

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

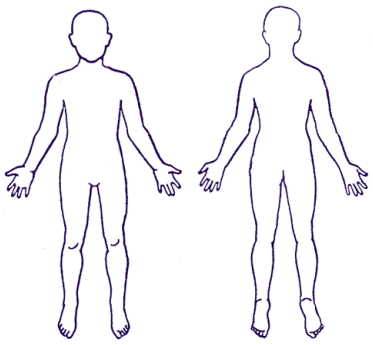
*all remedies/supplements are additional

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