

Your History

Last Name _____ First Name _____ Home Phone _____

Work Phone _____ Cell Phone _____ Email _____

Address _____ City _____

Postal Code _____ Occupation _____

Marital Status M S D W Date of Birth Day _____ Month _____ Year _____ Age _____

of Children _____ If you take any pills, drugs or vitamins please list:

Please list all Surgeries and date _____

Who referred you to our office? () Family member () Friend () The Voice Newspaper
() Google () Walk- by () Radio () TV () Other (Please describe _____)

Are you here for: () Preventative Care/Wellness () Health Problem

Your spinal cord controls every system in your body. Please circle the areas where you have pain:

() Neck L R () Shoulder L R () Wrist L R () Low Back L R () Sciatica L R () Knee L R () Foot L
R

Other _____

() Poor Vision/Hearing () Headaches () Migraines () Dizziness () Poor Memory () Anger

() Depression () Anxiety () Poor Sleep () Low Energy () Acid/Gas Digestive Issues

() Shortness of Breath () Constipation/ Diarrhea () Weakness in the Body

Other: _____

History of Physical, Chemical, Emotional Stress (eg. falls, smoking/drinking, loss of job etc)

By signing below - I acknowledge all information is true and give Dr. Sandy Bhasin full permission to carry out any exam of my spine including use of thermal scan and surface EMG.

Patient's Signature_____ Date_____

Dr. Sandy Bhasin's Signature_____ Date_____