EHL HEALTH · **ELSE HARRISHOJ LARSEN**, D.C., CCOS(C) Date_____

PATIENT INFORMATION

Last Name_____
First Name_____
Medical No_____
E-Mail_____
Would you like to receive e-mail reminders? ☐ Yes ☐ No

Address_____
_____
City_____
Province_____ Postal Code_____
Main Phone_____

CASE HISTORY UPDATE

Please provide dates and details of any of the following which you have experienced since your last treatment at the office:

Surgeries: _____

Work place accidents: _____

Motor vehicle accidents: _____

Falls, injuries or traumas: _____

List present complaints: _____

_____

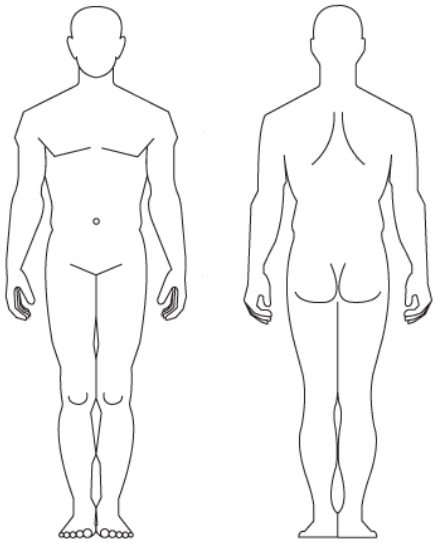
_____

Please specify any other care you have received for this problem: _____

_____

Please indicate problem area(s) by labeling them as:

A = Ache
N = Numbness
P = Pain
T = Tingling
X = Pins & needles



No Pain

1	2	3	4	5	6	7	8	9	10

Excruciating Pain