HEALTH INFORMATION & PERSONAL HISTORY

PATIENT INFORMATION

Full Name_________________________ Email Address_________________________________Occupation_________________________

Address_________________________________ Postal Code______________________ Care card #_______________________________

Home Phone #__________________________ Work Phone #_____________________________ Cell #___________________________

Height__________ Weight_________ Birthdate (d/m/y) ____/____/____

Referred by? ______________________________ Have you seen a Chiropractor before? When? ______________________________

Family Dr. ___________________________ Medications you take ____

Is this a WCB or ICBC case? Y___ N___ If yes, date of injury (d/m/y) _____/____/____ Claim #_________________________________

What is your major complaint? _____________________________ How long have you had this condition? ______________________

Has it occurred previously? Y___ N___ What activities aggravate your condition? ____

Have you consulted anyone regarding this condition? Who? ____

Did you receive treatment? ____

Is the condition getting: Worse____ Better ____ Comes and Goes___

Does the condition interfere with: Work____ Sleep____ Exercise____ Other____

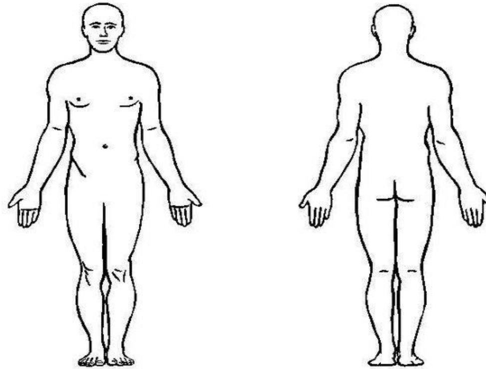
Do you exercise? Y ___ N ___ How, and how much? ____

TREATMENT PLAN

Your purpose in consulting this office is (please check):
___ Pain Relief ___ Learning how to correct/ prevent this condition ___ My Overall approach to health

Please indicate the problem area on the diagram using the code below to describe how you are feeling:

Pain = **XXXXX**
Numbness = **OOOOO**
Tingling = **+++++**
Spasm = **/////**
Burning = **-----**



PERSONAL

Y__N__ Have you ever had a significant trauma? (Vehicle Accident, Fall, Sport Impact etc.)

When?____

Y__N__ Were you injured? Y__ N__ Have you ever been hospitalized? For how long? ____

Was imaging done (MRI, X-ray)? How many and when? ______________________ Have you had surgery or operations? Y___N___

Please indicate if you have a history of the following.

Y__N__ Nervous Condition_______________________________ Y__ N__ Digestive Problems ________________________________

Y__ N__ Heart & Blood Vessel problems ____

Y__ N__ Chest or Respiratory problems____________________ Y__N__ Genital or Urinary condition_________________________