Date ____________________

Welcome to our clinic! Please fill out our Confidential Patient Health Record completely and accurately. If you have any questions, please don't hesitate to ask our front desk staff or your chiropractor.

PERSONAL INFORMATION

Name ______________________________ BC Medical # ______________________________

Address ____________________ City ________________ Province ______ Postal Code ____________

Home Phone # ________________________

Cell Phone # ________________________ ☐ Bell ☐ Telus ☐ Rogers ☐ Other ____________

Birth Date (mm/dd/yyyy) _____ / _______ / _______ Age _______ ☐ Male ☐ Female

Marital Status ☐ S ☐ M ☐ C/L ☐ D ☐ W E-Mail Address ______________________________

Spouse/Partner ______________ Children's names & ages ______________________________

Emergency Contact & Relationship ________________________ Phone number ________________

Occupation & Employer ________________________ Business phone ________________

Are you a student? ☐ Yes ☐ No If yes, where? ______________________________

How did you hear about our clinic? ☐ Personal referral: ________________________ ☐ Phone Book

☐ Internet ☐ Sign ☐ Health professional: ______________________ ☐ Other: ______________

Have you had any previous chiropractic care? ☐ Yes ☐ No If yes, with whom? ______________

Date of last treatment ______________ Were you happy with the results? ☐ Yes ☐ No

Current Family Physician: ________________________ Phone number ________________

May we contact your family physician for co-management? ☐ Yes ☐ No

Do you have Extended Health Benefits? Yes ☐ No ☐ Provider: ______________________________

Policy # __________ member # __________ Name and Date of Birth of card holder: ______________

REASON(S) FOR YOUR APPOINTMENT

Is the purpose of this appointment related to:

☐ Work ☐ Auto Accident ☐ Fall ☐ Sports ☐ Chronic Discomfort ☐ Wellness care ☐ Other

If job related, are you claiming under Worker's Compensation Board (WCB)? ☐ No ☐ Yes, Claim #: __________

If auto accident, are you claiming under Insurance Corporation of BC (ICBC)? ☐ No ☐ Yes, Claim #: __________

Briefly describe your main health concern(s): ______________________________

____

____

How long have you had this condition? ______________________________

Is your condition getting...worse / better / same? (circle one)

What makes the condition worse? ______________________________

What makes the condition better? ______________________________

What have you tried that has not worked? ______________________________

Have you seen any other healthcare professional for this complaint? ☐ Yes ☐ No

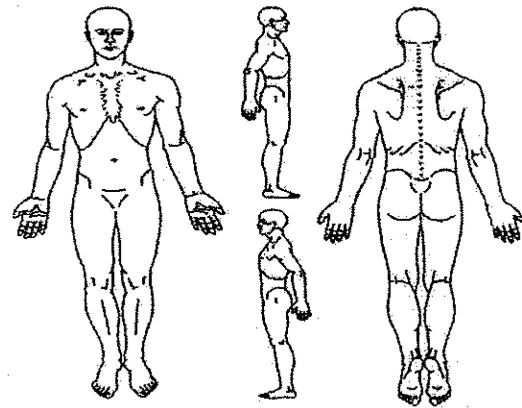
If yes, with whom: ________________ Date of last visit: ________________

Were x-rays or any other medical testing performed? ______________________________

List any treatments performed: ______________________________

Mark the areas of your body where you feel the described sensations.
Use the appropriate symbol, include ***ALL*** *affected areas.*

Ache: \\\\
Numbness: +++
Pins and Needles: ooo
Burning: BBB
Stabbing: SSS
Throbbing: TTT



Using the scale provided below, rate your ***current level of pain****:*

No pain 0 1 2 3 4 5 6 7 8 9 10 Debilitating

HEALTH HISTORY

Please mark ***C*** *beside the condition(s) you* ***presently have*** *(or experience on a recurring basis).*
Please mark ***P*** *beside the condition(s) you* ***have had in the past****.*

Musculoskeletal System
___ neck problems
___ jaw problems
___ upper back problems
___ shoulder problems
___ elbow/wrist problems
___ low back problems
___ ankle/foot problems
___ arthritis
___ osteoporosis
___ muscle soreness
___ scoliosis

Circulatory system
___ high blood pressure
___ high cholesterol
___ heart condition
___ aneurysm
___ stroke
___ varicose veins

Pulmonary
___ Asthma
___ chest pain
___ difficulty breathing
___ persistent cough

Nervous System
___ headaches
___ loss of feeling
___ numbness
___ dizziness
___ fainting
___ loss of balance
___ confusion
___ depression
___ forgetfulness
___ fatigue
___ anxiety

Gastrointestinal system
___ poor appetite
___ excessive hunger
___ abdominal pain
___ excessive thirst
___ nausea/vomiting
___ diarrhea
___ constipation
___ bloody/black stool
___ liver/gallbladder trouble
___ weight trouble
___ ulcer

Systemic
___ Diabetes
___ Hypoglycemia
___ Epilepsy
___ Rheumatoid
___ TB
___ HIV / AIDS
___ Cancer: ________
___ MS
___ Parkinson's
___ Thyroid problems
___ other: ________

Genito-Urinary system
___ painful urination
___ excessive urine
___ scanty urine
___ discolored urine

Allergies
___ seasonal
___ hay fever
___ sinus pain
___ drug
___ food
___ other: ________

Ear, Eyes, Nose, Throat
___ eye problems
___ vision problems
___ ear discharge
___ ear pain
___ ear ringing
___ hearing loss
___ sore throat
___ hoarseness
___ enlarged glands

Female
___ vaginal discharge
___ vaginal bleeding
___ pregnancy
___ menstrual pain
___ irregular cycle
Menopausal? ☐ Yes ☐ No
Pregnant? ☐ Yes ☐ No
Due date: ________

Men
___ prostate problems

Other ________
____

Had any broken bones? ☐ Yes ☐ No Explain ________
Been struck unconscious? ☐ Yes ☐ No Explain ________
Any significant accidents or injuries? ☐ Yes ☐ No Explain ________
Had surgery? ☐ Yes ☐ No Explain ________
Had any major strains or sprains? ☐ Yes ☐ No Explain ________
Use orthotics, heel lifts, or insoles? ☐ Yes ☐ No Explain ________

FAMILY HEALTH HISTORY

Please check any boxes that apply to anyone in your Family (not including you)

- ☐ High blood pressure
- ☐ Heart disease
- ☐ Stroke
- ☐ Diabetes (Type I or Type II)
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ High cholesterol
- ☐ Thyroid / Hormone problems
- ☐ Breathing or lung problems
- ☐ Cancer: ______
- ☐ Neurological problems
- ☐ Other: ______

HEALTH & LIFESTYLE

Your condition(s) may be affected by your environment, the foods you eat, and your lifestyle activities and habits. Please answer the following:

Please list any medications you are currently taking and for how long: ______

______

Please list any nutritional supplements you are currently taking and for how long: ______

______

Do you exercise regularly? ☐ No ☐ Moderate ☐ Daily Activities: ______

How would you describe your eating habits? ______

How many glasses of water do you drink per day? ______

Do you Smoke? ☐ Yes ☐ No If yes, how long and how much? ______

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? ______

Do you sleep well at night? ☐ Yes ☐ No If no, why? ______

Is your job stressful? ☐ Yes ☐ No If yes, why? ______

Have you had any recent changes in body weight? ☐ Yes ☐ No If yes, how much? ______

List any major life stresses over the last year: ______

List any enjoyable hobbies you participate in: ______

HEALTH GOALS

Are you satisfied with your current overall health? ☐ Yes ☐ No

What things would you like to change/improve about your current level of health? Please explain: ______

______

What is preventing you from achieving your goals? ______

Is there anything else that you are concerned about or would like advice about? ______

______

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understar
it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Signature of patient or legal gaurdian ______ Date ______

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Date: ______________________________

______________________________	______________________________
Patient Signature	*Name (Please Print)*
______________________________	______________________________
Witness Signature	*Name of Witness (Please Print)*

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