

# CONFIDENTIAL PATIENT HEALTH RECORD

## Personal History

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cellular: \_\_\_\_\_

Email Address: \_\_\_\_\_

Birth date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: Single  Married  Common law  Separated  Divorced  Widowed

Number of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

Business Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Who can we thank for referring you to our office: \_\_\_\_\_

Who is responsible for your bill? Private  WCB  ICBC  RCMP  DVA

Do you have extended health? Yes  No

## CURRENT HEALTH CONDITION

Mark Area of Complaint on Diagram

Purpose of this appointment \_\_\_\_\_

Secondary complaint(s) \_\_\_\_\_

Other practitioners seen for this condition? \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

Is this condition becoming worse? Yes  No  Varies

**Medications being taken:** None  Nerve pills  Pain killers  Muscle relaxants  Blood pressure  Aspirin

Thyroid  Anti-inflammatory  Insulin/diabetic material  Birth control pills  Other  \_\_\_\_\_

**Major Surgeries:** Gall bladder  Heart  Back  Neck  Hernia  Hysterectomy

Other  \_\_\_\_\_

Are there any other health conditions that we should be aware of? \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

Do you wear heel lifts? Yes  No  Orthotics? Yes  No

### Females Only:

Are you pregnant? Yes  No  Not sure

Date of last period \_\_\_\_\_

Intake	Amount/Day
<input type="checkbox"/> Coffee	_____
<input type="checkbox"/> Tea	_____
<input type="checkbox"/> Alcohol	_____
<input type="checkbox"/> Cigarettes	_____

Have you had previous chiropractic care? Yes  No  If yes, when did your care begin? \_\_\_\_\_  
 Length of time under care? \_\_\_\_\_ When were you last adjusted? \_\_\_\_\_  
 Name of chiropractor? \_\_\_\_\_ Were x-rays taken? \_\_\_\_\_ Date? \_\_\_\_\_

**Research is showing that many of the health challenges that occur later in life have their origins during the early years, some starting at birth. Please list even minor accidents or traumas.**

Auto accidents: \_\_\_\_\_  
 Fall / injuries: \_\_\_\_\_  
 WCB injuries: \_\_\_\_\_  
 Childhood / birth traumas: \_\_\_\_\_  
 Sports injuries: \_\_\_\_\_  
 Have you ever had any broken bones?  No  Yes Details: \_\_\_\_\_  
 Have you ever had a concussion?  No  Yes Details: \_\_\_\_\_  
 Do you have allergies?  No  Yes List: \_\_\_\_\_  
 Do you regularly exercise?  No  Yes Days per weeks? \_\_\_\_\_  
 Do you sleep well?  No  Yes How many hours? \_\_\_\_\_  
 Do you eat a healthy diet?  No  Yes  
 Do you take vitamins?  No  Yes List: \_\_\_\_\_

**We want to provide you with the best possible health care. To do this we will first need to understand what you want to achieve. Please mark the statement that most clearly reflects your health care objectives:**

- Wellness: I want to build my inner strength. I am conscious about my health, diet, exercise, etc. and actively pursue these because I feel better and it maximizes my potential.
- Treatment only: I only consult a health care practitioner when I have an ache or pain and discontinue care when it subsides.

I believe my commitment to health is: Important 1 2 3 4 5 6 7 8 9 10 Utmost Importance

If you could pick one outcome from your chiropractic care, what would it be? \_\_\_\_\_

**PATIENT – DOCTOR AGREEMENT**

<b>New Patient</b>	\$50.00	<b>X-Rays</b>	\$95.00 (full set) \$60.00 (half set)
<b>Regular Visit</b>	\$35.00	<b>SEMG</b>	\$10.00

All patients pay our regular office fees. However, the Medical Services Plan reimburses \$23.00 per visit up to 10 visits per year to **individuals receiving premium assistance**. These visits are inclusive of treatments by chiropractors, massage therapists, naturopaths, physiotherapists, and podiatrists. If you qualify for premium assistance our office will submit to the Medical Services Plan, on your behalf, and you will receive your reimbursement through the mail in four to six weeks. Submission to extended health plans is the patient's responsibility, receipts given upon request.

**PAYMENT IS DUE AT TIME SERVICES RENDERED**

***I UNDERSTAND AND AGREE TO THE FEE POLICY WITHIN THIS OFFICE. I ALSO UNDERSTAND THAT FEES ARE DUE WHEN SERVICES ARE RENDERED AND THAT I AM RESPONSIBLE FOR PAYMENT.***

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

