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: _____ **Subscribe** ☐ (consent to receive email reminders, newsletters)

☐ **Unsubscribe** (do not want to receive any communication)

Birth date: Month _____Day _____ Year _____ Age: _____

Marital Status: Single ☐ Married ☐ Common law ☐ Separated ☐ Divorced ☐ Widowed ☐

Number of Children: _____ Ages: _____

Business Employer: _____ Type of Work: _____

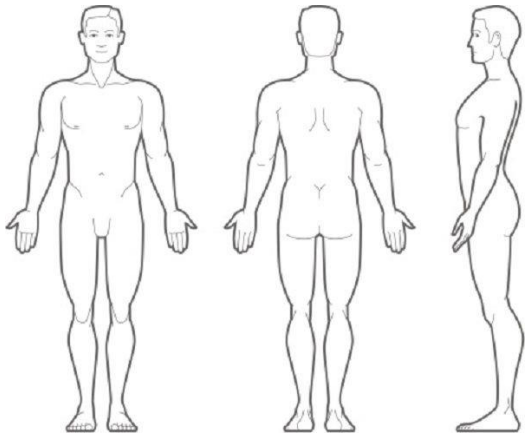
Who can we thank for referring you to our office?_____ OR I found you on: Google ☐ Yellow pages ☐ Sign ☐

Who is responsible for your bill? Myself ☐ WCB ☐ ICBC ☐ RCMP ☐ DVA ☐

Do you have extended health? Yes ☐ No ☐ If so, who is your provider? Blue Cross Other _____

CURRENT HEALTH CONDITION

Mark Area of Complaint on Diagram



Purpose of this appointment _____

_____

Secondary complaint(s) _____

_____

When did this condition begin? _____

Is this condition becoming worse? Yes ☐ No ☐ Varies ☐

Other practitioners seen for this condition? Physio ☐ Massage ☐ Acupuncture ☐ MD ☐ None ☐

Results_____

_____

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 ☐

Have you had Xrays/MRI/CT Scan taken? _____ Date(s):_____

Females Only:
Are you pregnant? Yes ☐ No ☐ Not sure ☐
Date of last period _____

Intake	Amount/Day
☐ Coffee	_____
☐ Tea	_____
☐ Alcohol	_____
☐ 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 correct the problem, and keep up a healthy nervous system to feel my best. I am conscious about my health, diet, exercise, etc. and actively pursue these because I feel better and it maximizes my potential.

☐ Improved Function: I want to reduce the symptoms And improve the function of my spine & body.

☐ Treatment for symptom relief 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

New Patient	$85.00	**X-Rays**	$110.00 (full set) $75.00 (half set)
Regular Visit	$60.00 Adults $55.00 Children $55.00 Student	**Update/Progress**	$70.00

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 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 _____

Have you ever been diagnosed with the following?

- ☐ Alcoholism
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Stomach ulcer
- ☐ Polio
- ☐ High blood pressure
- ☐ Irritable bowel / colitis
- ☐ Diabetes
- ☐ Anemia
- ☐ Heart disease
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Cancer
- ☐ Thyroid problems
- ☐ Eczema / skin condition
- ☐ Arthritis (osteo, rheumatoid)
- ☐ Asthma
- ☐ Arteriosclerosis
- ☐ Stroke
- ☐ Chrones disease
- ☐ Seizures

Have any of the following occurred? **P** = previously **C** = currently

P	C		P	C		P	C	
☐	☐	Depression	☐	☐	Divorce	☐	☐	Mood Swings
☐	☐	Death in family	☐	☐	Change in job status	☐	☐	Drug / alcohol over use
☐	☐	Anxiety	☐	☐	Increased work stress	☐	☐	Sleeping problems
☐	☐	Chronic fatigue	☐	☐	Family problems	☐	☐	Economic stress
☐	☐	Weight loss/gain	☐	☐	Nervousness	☐	☐	Tension
						☐	☐	Other _____

Family Health Information:
Many health problems are the result of hereditary spinal weakness. Thus, information about your family members will give us a better picture of your total health. Please list any member of your family who has <u>any</u> kind of health problem.

Name Relation Problem

_____

_____

Please check (4) all symptoms which apply to you, even if they do not seem related to your current problem.
P = Previously (over 1 year ago) **C** = Currently (during last year)

P	C		P	C		P	C	
☐	☐	Headaches	☐	☐	Dizziness / loss of balance	☐	☐	Gas / bloating
☐	☐	Migraines	☐	☐	Frequent nausea	☐	☐	Stomach problems
☐	☐	Neck stiffness / pain	☐	☐	Loss of smell / taste	☐	☐	Heartburn
☐	☐	Arm or shoulder pain	☐	☐	Buzzing / ringing in ears	☐	☐	Constipation
☐	☐	Elbow / hand pain	☐	☐	Fainting	☐	☐	Diarrhea
☐	☐	Pain between shoulders	☐	☐	Cold Sweats	☐	☐	Hemorrhoids
☐	☐	Cold hands / feet	☐	☐	Fever	☐	☐	Blood in stools
☐	☐	Back pain / stiffness	☐	☐	Vomiting			
☐	☐	Difficulty walking	☐	☐	Irritability			
☐	☐	Leg pain						
☐	☐	Foot / ankle pain	☐	☐	Incontinence	☐	☐	Liver problems
☐	☐	Knee Pain	☐	☐	Urinary / bladder problems	☐	☐	Gall bladder problems
☐	☐	Hip pain	☐	☐	Painful urination	☐	☐	Prostate dysfunction
			☐	☐	Colitis	☐	☐	Sexual dysfunction / pain
☐	☐	Wheezing				☐	☐	Hot flashes
☐	☐	Chest pain	☐	☐	Earaches or infections	☐	☐	Menstrual pain / cramping
☐	☐	Irregular heart beats	☐	☐	Hearing difficulty	☐	☐	Menstrual irregularity
☐	☐	Lung problem / congestion	☐	☐	Stuffed nose due to allergies			
			☐	☐	Other sinus problems			

Numbness or Tingling In

P	C		P	C	
☐	☐	Shoulders	☐	☐	Knees
☐	☐	Arms	☐	☐	Feet
☐	☐	Elbows	☐	☐	Hips
☐	☐	Hands	☐	☐	Legs

In what position do you sleep?

☐ Side ☐ Front ☐ Back

Patient's Signature: _____ Date _____