

PERSONAL HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help determine if Chiropractic can help you. Please answer ALL questions, even if they seem unrelated to your case. There are conditions Chiropractic can help that you may be unaware of. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name _____ Birthdate mm/dd/yyyy _____ Date _____
BC Health Card # _____ Phone: (home) _____ (office) _____
Address _____ (cell) _____
City&Prov. _____ Postal Code _____ Email _____
Marital Status _____ Age _____ Weight _____ Height _____ Children _____
Employer _____ Occupation _____
Who referred you to this office (Name if possible) _____

CURRENT HEALTH CONDITION

Reason for consulting this office _____
Have you had any previous treatment for this condition? _____
When did this condition begin? _____
What do you believe caused this condition? _____
Are there others in your family with this same condition? _____
What aggravates your condition? sitting standing bending lifting walking
What relieves your condition? _____
Have you had any time loss from work for this condition? (if recent, list dates) _____
Is this a WCB or ICBC case? _____ If yes - date of accident _____
WCB/ICBC Claim# _____ WCB/ICBC Adjuster name _____
Are you presently taking any medications? (Please mention) _____
Have you had any x-rays taken in the past year? _____ If yes, where? _____
Do you wear heel lifts or orthotics? _____
How has this problem affected your everyday life? _____

PAST HEALTH HISTORY

Major surgery / operations: C-section Hernia Gall Bladder Knee
 Heart Back Neck Leg Other _____
Major accidents or falls: (please describe) _____
Previous Chiropractic Care: Doctor's name and approximate date of last visit _____
Have you been treated for any health condition in the last year? _____
If yes, please explain _____
Family Physician _____ Phone _____

Check any conditions which are presently causing you a problem. Please underline problems that were in the past.

GENERAL

- headache
- numbness or pain in arms or legs
- dizziness
- ringing in ears
- whiplash
- fainting
- earache
- sore throat
- nose bleeds
- sinus problems
- asthma
- enlarged glands
- loss of weight
- nervousness
- depression / anxiety
- vision problems
- dental problems
- hearing problems

ORGANS

- painful urination
- frequent urination
- blood in urine
- bladder trouble
- kidney stones
- bed wetting
- prostate problems
- sexual dysfunction
- anemia
- thyroid
- acid reflux
- excessive appetite
- gas/bloating
- nausea or vomiting
- constipation/diarrhea
- colitis
- black/bloody stool
- liver trouble
- gall bladder trouble

SKIN

- eczema
- skin eruptions
- varicose veins

MUSCLE & JOINT

- low back problems
- sore joints
- painful tailbone
- pain between shoulders
- spinal curvature
- arthritis
- sore muscles
- walking problems
- broken bones
- difficulty chewing/ clicking jaw
- ankle swelling
- limb pain
- neck pain

RESPIRATORY & HEART

- lung problems
- chronic cough
- spit up blood
- frequent colds/flu
- shortness of breath/ difficult breathing
- heart problems
- chest pain/angina

FEMALES ONLY

- painful periods
 - irregular cycle
 - cramps, backache
 - lumps/pain in breast
 - menopausal symptoms
 - previous miscarriage
 - unable to get pregnant
 - hot flashes
 - are you pregnant?
 - yes no unsure
- When was your last period?
-

Check any of the following diseases you have had:

- alcoholism
- epilepsy
- stroke
- arthritis
- hypoglycemia
- hepatitis or HIV/AIDS
- tuberculosis
- diabetes
- cancer
- allergies
- heart disease
- high/low blood pressure
- osteoporosis
- respiratory conditions
- hemophilia
- Other _____

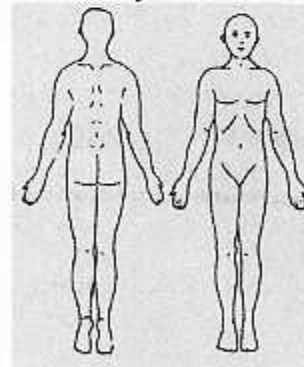
Has anyone in your family had any of the following diseases?

- heart disease
 - high blood pressure
 - stroke
 - cancer
 - arthritis
 - diabetes
- other _____

HABITS

	None	Light	Moderate	Heavy
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Junk Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please outline on the diagram
The area of your discomfort.



Do you take any vitamins, minerals or herbal products? _____

Do you play / participate in any sports? _____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? (Local and/or closest relative)

Name: 1) _____ Phone: _____
 2) _____ Phone: _____