

# CONFIDENTIAL PATIENT HISTORY FORM

Name \_\_\_\_\_ Health Card # \_\_\_\_\_

Mailing Address \_\_\_\_\_

Phone \_\_\_\_\_ Birth Date \_\_\_\_\_

Married  Single  Other  Children \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Is this visit related to WBC or ICBC ? \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

What medications are you presently taking or have been taking? \_\_\_\_\_

Have you ever been involved in an accident? Please Explain: \_\_\_\_\_

Broken Bones? Dislocation? \_\_\_\_\_

Any other major illnesses, surgery, discomfort? \_\_\_\_\_

Your main complain and symptoms are? \_\_\_\_\_

When did you first notice the pain? \_\_\_\_\_

What brought it on? \_\_\_\_\_

What activities aggravates this condition? \_\_\_\_\_

Is the condition getting progressively worse? Yes  No  Constant

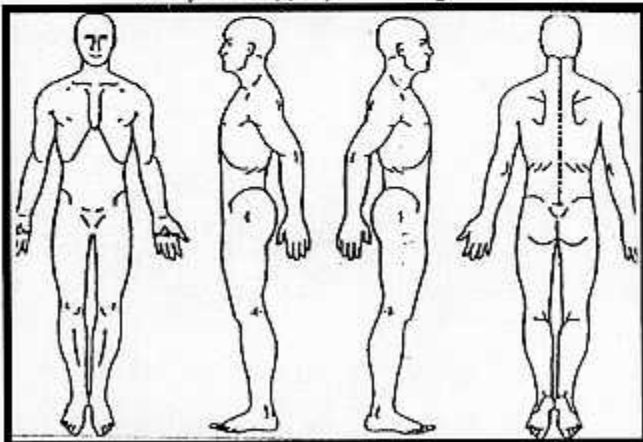
Is this condition interfering with: Work  Sleep  Daily Routine

What have you done to get relief? \_\_\_\_\_

Have you had similar problems before? \_\_\_\_\_

Is there serious stress in your life right now? \_\_\_\_\_

Mark your area (s) of pain in the figure below.



Have you ever experienced any of the following? (Check all that apply)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Tumor or Cyst     | <input type="checkbox"/> Acute Inflammation     |
| <input type="checkbox"/> Nervousness         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Back Pain     | <input type="checkbox"/> Dislocation            |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Pregnancy         | <input type="checkbox"/> Skin Disease           |
| <input type="checkbox"/> Sinus Trouble       | <input type="checkbox"/> Allergies           | <input type="checkbox"/> Varicose Veins    | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Heart Trouble       | <input type="checkbox"/> Ringing in ears     | <input type="checkbox"/> Phlebitis         | <input type="checkbox"/> Prostate               |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Eye Pain            | <input type="checkbox"/> Lumps in Breast   | <input type="checkbox"/> Frequent Urination     |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Nausea              | <input type="checkbox"/> Poor Circulation  | <input type="checkbox"/> STD                    |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Loss of Sleep       | <input type="checkbox"/> Cold Feet / Hands | <input type="checkbox"/> Menstrual Problems     |
| <input type="checkbox"/> Neuritis            | <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Bruise Easy       | <input type="checkbox"/> Loss of Skin Sensation |

Your appointment time is reserved especially for you. If you find it necessary to reschedule an appointment, a minimum of 4 hours is required. Otherwise you will be charged the full treatment amount. Thank you for your understanding and cooperation. I understand and agree to the fee policy and acknowledge that I am responsible for payment.

Signature \_\_\_\_\_ Date \_\_\_\_\_