arise
CHIROPRACTIC
MASSAGE • PHYSIO
WELLNESS CORPORATION

Personal Information

Your name: _____
First Last

Birth date: _____ Age: _____

Occupation: _____

B.C. Personal Health Number: _____

Is your visit today WCB or ICBC related? _____

Address: _____

City: _____ Postal Code: _____

Telephone: Home: _____ Cell: _____

Email address: _____

Emergency Contact: _____
First Last Phone

Referred to our clinic by: _____
(eg. Family/Friends name, Google, Facebook advertisement)

Note: Your email will be used as a secondary contact and occasionally clinic info (i.e specials and event info) might be sent to you. You can unsubscribe at any time if you choose.

HEALTH HISTORY

Reasons for your visit: (Please list in order of priority)

1) _____ 3) _____

2) _____ 4) _____

How long have you had this problem? _____ How did it occur? _____

_____

Did the problem occur [ ] immediately [ ] gradually. Did this ever happen before? [ ]Yes [ ] No.

If yes, when? _____

The problem: [ ] Comes and Goes [ ] Is Constant

The problem seems to be : [ ] Getting Better [ ] Getting Worse [ ] Remaining the Same

What makes it better? _____What makes it worse? _____

Have you seen a health practitioner about this problem? [ ] Yes [ ] No.

Dr./Therapists Name: _____ When?_____

What treatment/tests were performed? _____

Have the previous treatments helped? [ ] Yes [ ] No.

If yes, describe:_____

Have you ever had chiropractic care? [] Yes [] No. If yes, Dr.'s Name:_____

When was your last visit?_____ Reason for visit?_____

Do you sleep on your: [ ] Back [ ] Side [ ] Stomach

Are you on any medication? [ ] Yes [ ] No. If yes, please list:_____

_____

Please list any surgeries you have had: _____

Have you had any accidents or injuries? Please describe: _____

****

DOCTOR'S NOTES:

_____

_____

_____Date:_____

Name:_____

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD:

MUSCULOSKELETAL
[ ] Arthritis
[ ] Low Back Pain
[ ] Pain Between Shoulders
[ ] Neck Pain
[ ] Arm Pain
[ ] Walking Problems
[ ] Jaw Problems

NERVOUS SYSTEM CODE
[ ] Numbness
[ ] Epilepsy
[ ] Paralysis
[ ] Dizziness
[ ] Forgetfulness/Confusion
[ ] Depression
[ ] Mental Disorder
[ ] Fainting
[ ] Convulsions
[ ] Cold/Tingling Extremities

GENERAL CODE
[ ] Allergies
[ ] Loss of Sleep
[ ] Fever
[ ] Headaches

GENITO-URINARY CODE
[ ] Discoloured Urine
[ ] Bladder Trouble
[ ] Painful/Excessive Urination

C-V-R CODE
[ ] Smoke Cigarettes
[ ] Lung Problems
[ ] Asthma
[ ] Irregular Heartbeat
[ ] Diabetes
[ ] Chest Pain
[ ] Short Breath
[ ] Ankle Swelling
[ ] Varicose Veins
[ ] Stroke
[ ] Heart Attack
[ ] High Blood Pressure

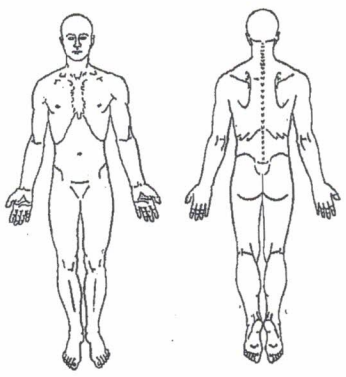
EENT CODE
[ ] Stuffed Nose
[ ] Vision Problems
[ ] Dental Problems
[ ] Sore Throat
[ ] Ear Aches
[ ] Hearing Difficulty

GASTRO-INTESINAL CODE
[ ] Excessive Thirst
[ ] Frequent Nausea
[ ] Colitis
[ ] Crohns
[ ] Vomiting
[ ] Diarrhea
[ ] Constipation
[ ] Hemorrhoids
[ ] Weight Trouble
[ ] Abdominal Cramps
[ ] Poor/Excessive Appetite
[ ] Gas/Bloating After Meals

MALE / FEMALE CODE
[ ] Menstrual Irregularity
[ ] Menstrual Cramping
[ ] Vaginal Pain/Infections
[ ] Breast Pain/Lumps
[ ] Prostate/Sexual Dysfunction

FEMALES ONLY:
When was your last period?_____
Are you pregnant? [ ] Yes
[ ] No
[ ] Maybe

SHOW US WHERE IT HURTS



OTHER CONDITIONS
[ ] AIDS
[ ] Scarlet Fever
[ ] Diphtheria
[ ] Typhoid Fever
[ ] Pneumonia
[ ] Alcoholism
[ ] Eczema
[ ] Venereal Infection
[ ] Small Pox
[ ] Anemia
[ ] Cancer
[ ] Thyroid
[ ] Liver Trouble
[ ] Gall Bladder
[ ] Rheumatic Fever
[ ] Polio
[ ] Malaria
[ ] Tuberculosis
[ ] Whooping Cough

List any other conditions or problems you feel may be important:_____

_____

Date_____