



## 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: \_\_\_\_\_

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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

**OTHER CONDITIONS**

- AIDS
- Scarlet Fever
- Diphtheria
- Typhoid Fever
- Pneumonia
- Alcoholism
- Eczema
- Venereal Infection
- Small Pox
- Anemia
- Cancer
- Thyroid
- Liver Trouble
- Gall Bladder

**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**

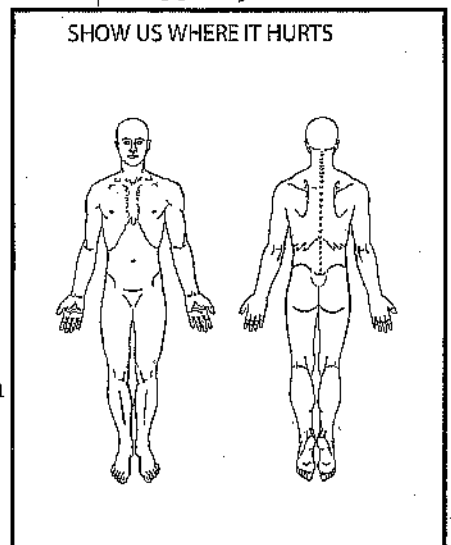
- Excessive Thirst
- Frequent Nausea
- Colitis
- Crohns
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Weight Trouble
- Abdominal Cramps
- Poor/Excessive Appetite
- Gas/Bloating After Meals

**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



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

Date \_\_\_\_\_