Today's Date (Month.Day.Year) : _____ . _____ . _____

Please take a few moments to help us know you better

Title: Mr. / Mrs./ Miss./ Ms. **Gender**: M / F **Birthday** (Month.Day.Year): _____ . _____ . _____

Last Name : _____ **First Name** : _____

Marital Status: Single / Married / Common Law / Divorced / Widowed

Number of Children: _____ Their Ages_____ Care Card #: _____

Occupation : _____

Contact

Address : _____

City : _____ **Province:** _____ **Postal Code**: _____

Tel Num : (Home) _____ (Mobile) _____ (Work) _____

E-mail: _____ (email will only be used for office communications)

You are consulting us today for which service? ☐ Chiropractic ☐ Laser Therapy ☐ Acupressure ☐ Yoga ☐ Pilates ☐ Quit Smoking Program ☐ Weight Loss Program

How did you hear about our office?

☐ Referred by current practice member/other health professional : (please name) _____

☐ Website ☐Walk By ☐Facebook ☐ Advertisement : _____

Will you be claiming with:

☐ Extended Health Insurance ☐ MSP ☐ ICBC (Car Accident) ☐ WCB (Work Injury) ☐ Date of Accident/Injury_____

Please list any recent treatments or therapies (past 6 months)

☐ None ☐ Yes, provide name of M.D. _____

Chiropractor _____ Dentist _____

Massage Therapist _____ Others _____

Please list any recent test/examination:

☐ X-ray (area) _____ ☐ CT Scan ☐ MRI ☐ Blood Work ☐ Others _____

List the top 3 stressors in your life? (e.g. work, time management, relationships, money, etc.)

1.	2.	3.

PLEASE CHECK WHICH OF THE FOLLOWING YOU HAVE EXPERIENCED ☑ IN THE PAST YEAR ☒ PREVIOUS TO PAST YEAR

(even if they do not seem related to your current problem):

☐ Headaches/Migraines	☐ Back Pain/Stiffness	☐ Thyroid	☐ HIV
☐ Fatigue	☐ Neck Pain	☐ Irritability/ Mood Swings	☐ STD's/VD
☐ Tension/Stress	☐ Numbness in Fingers/Toes	☐ Diarrhoea	☐ Circulatory
☐ Depression	☐ Pins & Needles in Arms/Legs	☐ Constipation	☐ Diabetes
☐ Insomnia	☐ Dislocation	☐ Hot Flashes	☐ High Blood Pressure
☐ Dizziness/ Nausea	☐ Sprain/Strain	☐ Problems Urinating	☐ Varicose veins
☐ Loss of Balance	☐ Jaw/TMJ problems	☐ Menstrual Irregularity	☐ Stroke
☐ Buzzing in Ears	☐ Fractures	☐ Menstrual Pain	☐ Heart Condition
☐ Ringing in Ears	☐ Shortness of Breath	☐ Sensitive Eyes	☐ Epilepsy
☐ Cold Sweat	☐ Nervousness	☐ Allergies	☐ Kidney Problems
☐ Cold Hands/Feet	☐ Heartburn/Ulcers/Reflux	☐ Arthritis	☐ Head Injury
☐ Fever		☐ Cancer	☐ Spinal Injury
☐ Fainting			☐ Other:_____

You would describe your health as? □ Poor □ Could Improve □ Excellent

What areas of your health would you like to see improve?

-
-
-
-

What do you think could be causing any present health concerns?

(e.g. birth process; poor posture at work or school; previous injuris; poor lifestyle habits; poor diet; alcohol abuse; cigarette smoking; drug abuse; poor stress or time management)

-
-
-
-

Is there any history of the following in you or your immediate family? (please check):

□ Cancer □ Heart Disease □ Stroke □ Diabetes □ Unexplained Weight Changes □ Smoker

Check if you have or wear any of the following. List for how long you had them.

□ pins/plates _____ □ orthotics _____ □ dental appliance _____

Tell us a little about your health medical history. List and provide approximate dates for any of the following:

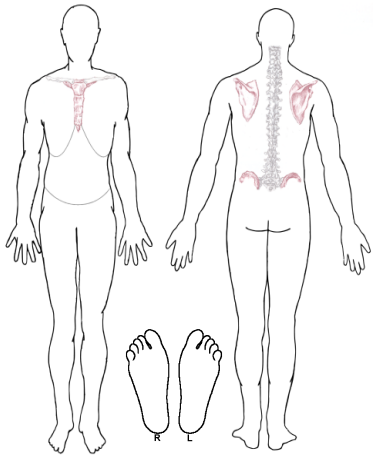
□ Surgeries _____ □ Falls _____

□ Fractures _____ □ Concussions/Unconsious _____

□ Car Accident _____ □ Others _____

Are you presently taking any medications? If yes, what type and for what condition

_____



Please mark on the diagram any area of concern and describe below:

✕ sharp pain
O dull pain
✓ numbness/tingling
🡻 weakness/fatigue
🡹 muscle tightness

_____

_____

_____

_____

_____

Please rate any pain you experience by circling **TWO numbers** that **best** describes your pain **at its BEST** and it its WORST in the past week.

1 2 3 4 5 6 7 8 9 10

No Pain *Intorable Pain*

Circle the **one number** that best describes how, during the **past week**, pain may have **interfered with your general activity.**

1 2 3 4 5 6 7 8 9 10

Does not Interfere *Completely Intereferes*

_____ _____

Patient Signature (Legal Guardian) Witness Signature

Patient Name : _____ Witness Name : _____