1065 Cambie Street Vancouver BC V6B 5L7 (604) 687-2900

Wellness and Rehabilitation Services

CHIROPRACTIC PATIENT INTAKE FORM

Name____ Today's Date _______/____/________
(LAST) (FIRST) (INITIAL) MM/DAY/YEAR

MSP CARE CARD NUMBER____________________ E-mail Address___________________________

Address_______________________________________ ( ) Mobile Number______________________

_________________________Postal Code_________ ( ) Alternative Number___________________

Employed By____________________________________ ( ) Work Number________________________

Occupation/Profession_____________________________ **For Emergencies, please check (✓) the best number above to reach you.**

Sex **M/F** Date of birth________/____/____________ Age_______ Number of Children_________
MM/DAY/YEAR

Spouse/Partner's Name_________________________Referred By____________________________

Family Doctor_________________________________ Date of Last Physical Exam: _______________

Have you had Chiropractic care before? **Y/N** By Whom?__________________When?______________

Do you have reason to believe you may be pregnant? **Y/N** Due date____________________________

Do you belong to a fitness facility? **Y/N** If yes, name and location_____________________________

Do you have extended health insurance? **Y / N**
Is this an ICBC Claim? **Y / N**
Is this a Worker's Compensation Claim? **Y / N**

I am responsible for my health and I understand that all appointments I book at this clinic are especially reserved for me and that I am responsible for payment of all services rendered. A $20 charge will be applied to accounts for missed appointments unless 24 hours notice of cancellation is given. Initials _________

If you have Extended Health Insurance, we are happy to assist you with providing receipts. However, I understand that it is the patient's responsibility to ensure coverage. Initials __________

I consent to electronic communications from this office. I understand that I may opt out of this at anytime. Initials _______

____

Signature

PacificChiropractic
and Massage Therapy

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HEALTH HISTORY

Pain and discomfort can be traced back to many different origins. To obtain a complete picture of your overall health, please complete the following form.

Please mark your complaint below, and mark the affected area(s) on the figure shown here.

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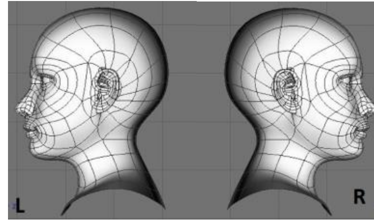

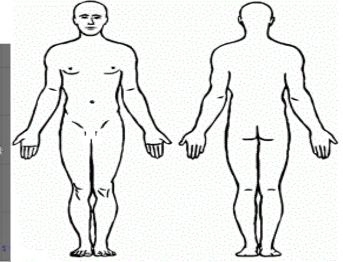

If you are having any of the following, please check.

- ❑ headaches
- ❑ shooting head pains
- ❑ sinus trouble
- ❑ loss of smell
- ❑ hay fever
- ❑ asthma
- ❑ loss of taste
- ❑ tightness of throat
- ❑ face flushed
- ❑ twitching of face
- ❑ fatigue
- ❑ depression
- ❑ head feels too heavy
- ❑ loss of memory
- ❑ neck pain
- ❑ fainting
- ❑ dizziness
- ❑ loss of balance
- ❑ ringing in the ears or pain
- ❑ problems with vision
- ❑ jaw clicking or pain
- ❑ muscle spasms in neck
- ❑ grating or grinding in neck
- ❑ tightness of shoulder muscles
- ❑ pins and needles in arms/hands
- ❑ cold hands
- ❑ heart or chest pains
- ❑ shortness of breath
- ❑ heart palpitations
- ❑ mid back pain
- ❑ heart attacks
- ❑ high blood pressure
- ❑ low blood pressure
- ❑ anemia
- ❑ stomach trouble
- ❑ ulcers
- ❑ nerves & nervousness
- ❑ irritability
- ❑ cold sweats
- ❑ rheumatic fever
- ❑ liver trouble
- ❑ gall bladder trouble
- ❑ indigestion
- ❑ intestinal gas
- ❑ low back pain
- ❑ constipation
- ❑ kidney trouble
- ❑ menstrual cramps
- ❑ diabetes
- ❑ cancer
- ❑ sleeping problems
- ❑ painful joints
- ❑ swollen joints
- ❑ arthritis
- ❑ pinched nerves in legs
- ❑ swollen ankles
- ❑ cold feet
- ❑ pains in legs and feet
- ❑ pins & needles legs/feet
- ❑ slipped disc

Lifestyle History

Do you smoke? ❑NO ❑YES If yes, how many years?______________________________

Do you consume alcohol? ❑NO ❑YES If yes, how many ounces per week? ______________________

Rate your sleep, hours per night: ❑4-6 ❑6-8 ❑8-10 ❑10-12 ❑12+

Do you feel rested upon waking? ❑NO ❑YES If No, explain why? ______________________________

How would you describe your current diet?

❑Poor ❑Average ❑Good ❑Excellent ❑Elite

Rate your appetite:

❑Poor ❑Average ❑Good ❑Excellent ❑Elite

How often do you eat? ❑1meal ❑2 meals ❑3 meals ❑4 meals ❑5 or more meals

Do you currently take any vitamins or supplements? ❑NO ❑YES If yes, please list ______________________

Do you currently use any braces, supports or orthotics? ❑NO ❑YES If yes, please list: ______________________

Please list any current medications you are taking:______________________________

Have you ever been hospitalized? ❑NO ❑YES If yes, please explain: ______________________

Please list any surgeries or operations and dates: ______________________________

Have you ever had any serious accidents (motor vehicle), falls, or injuries? Please list: ______________________

Do you currently suffer any residual symptoms or pain from any of the above? ❑NO ❑YES

Any family health conditions or problems? Please List: ______________________________

SIGNATURE______________________________ **DATE:** ______________________________