PATIENT INFORMATION FORM

DATE: _____

NAME: _____

For Office Use Only	
❑ G1 (user's fee)	❑ Exempt
❑ DVA	❑ RCMP

B.C. PERSONAL HEALTH NUMBER: _____

IF YOU HAVE EXTENDED HEALTH BENEFITS - YOU MAY BE ELIGIBLE FOR REIMBURSEMENT

ADDRESS: _____

CITY: _____ PROV: _____ POSTAL CODE: _____

SEX: ❑ M ❑ F DATE OF BIRTH: ____ (YEAR) / ____ (MONTH) / ____ (DAY) AGE: _____

HOME PHONE: _____ BUSINESS PHONE: _____

OCCUPATION: _____ EMPLOYER: _____

Email address: _____

IS THIS A WORK RELATED INJURY? ❑ NO ❑ YES CLAIM #: _____

MOTOR VEHICLE ACCIDENT INJURY? ❑ NO ❑ YES CLAIM #: _____

DATE OF ACCIDENT: _____

PREVIOUS CHIROPRACTIC CARE? ❑ YES ❑ NO

BY WHOM: _____ WHEN: _____

ARE YOU CURRENTLY SEEING ANOTHER PRACTITIONER? ❑ NO ❑ YES

❑ MASSAGE THERAPIST ❑ PHYSIOTHERAPIST ❑ NAME: _____

WHO REFERRED YOU TO THIS OFFICE? _____

WHO IS YOUR MEDICAL DOCTOR: _____

DO YOU HAVE REASON TO THINK YOU ARE PREGNANT? ❑ NO ❑ YES

HAVE YOU EVER:	YES	NO	*If yes, briefly explain:*
Had a motor vehicle accident?	❑	❑	_____
Been struck unconscious?	❑	❑	_____
Had a broken bone?	❑	❑	_____
Used a cane, crutch or other support?	❑	❑	_____
Been hospitalized / had surgeries?	❑	❑	_____
Been hospitalized for other than surgery?	❑	❑	_____
Had any falls or other injuries?	❑	❑	_____

DO YOU:	YES	NO	
Take minerals, herbs, or vitamins?	❑	❑	_____
Have any allergies?	❑	❑	_____

WHEN DID YOU LAST HAVE:	Never	0-6 mo	6-18 mo	Longer	
Spinal x-ray	❑	❑	❑	❑	_____
Spinal examination	❑	❑	❑	❑	_____
Physical examination	❑	❑	❑	❑	_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS:

❑ pain killers ❑ muscle relaxants ❑ anti-inflammatories ❑ cold medications

❑ other _____

PLEASE LIST ANY SIGNIFICANT ILLNESS OR MEDICAL CONDITION, PAST OR PRESENT:

_____

_____

BRIEFLY DESCRIBE YOUR PRESENT COMPLAINT: _____

_____

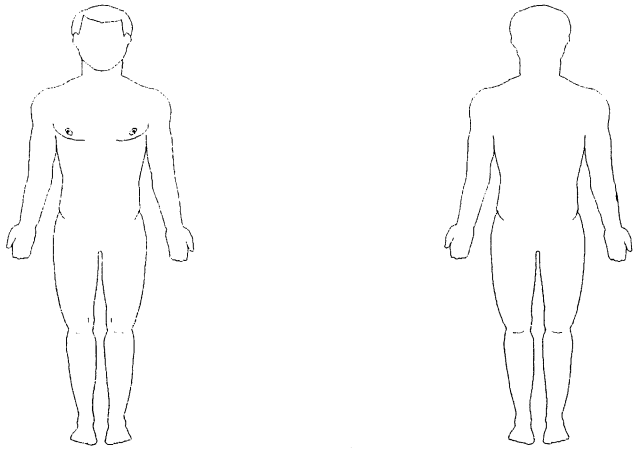
DO YOU HAVE DIFFICULTY WITH THE FOLLOWING? IF YES, MARK "X".

❑ HEADACHES	❑ SHOULDER, ARM OR HAND PAIN	❑ LOW BACK PAIN
❑ VISION BLURRY/CHANGE	❑ CHEST PAINS	❑ HIP, LEG or FOOT PAIN
❑ LOSS OF SMELL/TASTE	❑ SHORTNESS OF BREATH	❑ TINGLING / NUMBNESS IN LEGS or FEET
❑ RINGING IN EARS	❑ STROKE	❑ IRRITABILITY
❑ JAW PAIN	❑ MID-BACK PAIN	❑ SLEEPING PROBLEMS
❑ TIGHTNESS OF THROAT	❑ STOMACH COMPLAINTS	❑ MEMORY LOSS
❑ DIZZINESS / FAINTING	❑ ABDOMINAL PAIN	❑ STIFF/PAINFUL JOINTS
❑ LOSS OF BALANCE	❑ CONSTIPATION/DIARRHEA	❑ CANCER
❑ NECK PAIN	❑ MENSTRUAL CRAMPS, PAIN OR IRREGULARITY	❑ DIABETES
❑ TINGLING OR NUMBNESS IN ARMS OR HANDS	❑ HEAD INJURY	❑ EPILEPSY
❑ SPINAL INJURY		❑ BLOOD PRESSURE HIGH OR LOW

❑ OTHERS (PLEASE EXPLAIN): _____

_____

PLEASE MARK ON THE DIAGRAM THE AREA(S) OF YOUR DISCOMFORT



PLEASE RATE THE LEVEL OF PAIN YOU ARE FEELING TODAY (PLEASE MARK THE LINE).

NOT AT ALL UNPLEASANT — MOST UNPLEASANT IMAGINABLE