Cowichan Valley Chiropractic and Wellness

Patient Information and History

Date:_____

1 Patient Information

Name:_____
(First) (Initial) (Last)

Address:_____

_____Postal Code_____

Birth date: mo._____ day: _____year:_____

Age:_____ ▯ Male ▯ Female

Employer:_____

Parent's name (if a minor):_____

▯ Single ▯ Married ▯ Divorced
▯ Widowed ▯ Separated

Spouse's name:_____

# of Children: _____

2 Insurance

BC CARE CARD#:_____

Additional Insurer: □ Yes □ No

If yes:

Ins. Company Name: _____

Plan #:_____

Member ID:_____

3 Contact Information

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Best way to reach you: ▯Home ▯Cell ▯Work ▯Email

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Home phone: _____

Work Phone: _____

Cell Phone: _____

4 Accident Information

Is your condition due to an accident?:

▯Yes ▯No Date: _____

Type of accident:

▯Auto▯Work▯Home▯Sport ▯Other

To whom have you reported the accident?:

□ WCB □ Employer □ ICBC □ Other

Attorney's name (if applicable):_____

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How did you hear about us?

_____

May we contact your medical doctor? __

Name: _____

6 Patient Condition

What is your major symptom/complaint? _____

When did your symptoms begin?: _____

Have you had this problem before?: _____

Is your condition getting worse?: □ Yes □ No

Is this problem: □ Constant □ Comes and goes

How does it feel?: □ Burning □ Sharp □ Shooting □ Dull □ Achy
□ Stiff □ Tingling □ Throbbing □ Swelling □ Other_____

Circle below the severity of your pain on a scale of 0 to 10
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

What makes your condition better?: _____

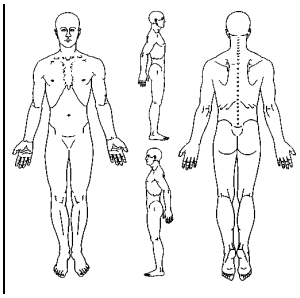
What makes your condition worse?: _____

Does it interfere with your ▯Work ▯Sleep ▯Daily Routine ▯Recreation

Activities/movements that are painful to perform:

▯Sitting ▯Standing ▯Walking ▯Bending ▯Lying down ▯Driving ▯Reading ▯Getting up

Please mark where it hurts



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Please continue on the back page…

Health history

What other treatments have you had for this condition?

□ Chiropractic □ Orthopedic □ Neurologist □ Physical Therapy □ Medication □ Surgery

Name of other doctors who have treated this condition:_____

Describe the other doctors treatment for your condition:_____

Previous Chiropractic care?: □ Yes □ No Date:_____ Local?: □ Yes □ No

Date of last: Physical exam_____ X-Ray_____ MRI_____

Spinal exam_____ Dental exam:_____ CT_____

List of Medications:_____

List of Supplements:_____

Females: Are you pregnant?: □ Yes □ No Beginning of last menstrual cycle:_____

Check any of the following conditions which you have had:

□ Aids/HIV	□ Ear ringing	□ Neck pain
□ Allergies	□ Epilepsy	□ Osteoporosis
□ Anxiety/depression	□ Headaches	□ Poor circulation
□ Arm/shoulder pain	□ Headaches (migraine)	□ Prostate problems
□ Arthritis	□ Heart disease	□ Rheumatoid Arthritis
□ Asthma	□ Hemorrhoids	□ Sciatica
□ Bladder problems	□ Herniated disk	□ Shingles
□ Cancer	□ High blood pressure	□ Sinus Infection
□ Chronic fatigue	□ Insomnia	□ Stroke
□ Deafness	□ Irregular cycle	□ Thyroid problems
□ Diabetes	□ Kidney problems	□ TMJ
□ Digestion problems	□ Leg pain	□ Venereal disease
□ Earache	□ Low back pain	□ Vertigo/Dizziness

Stressors:

□ Smoking . . . . . Packs per day:_____

□ Alcohol . . . . . Drinks per week:_____

□ Coffee/Caffeine drinks . . . . . Cups per day:_____

□ High Stress Levels . . . . . Reason:_____

Exercise:

□ None

□ Moderate

□ Daily

□ Heavy

Have you had any:	**Description**	**Date:**
Automobile accidents:		
Surgeries:		
Broken bones:		
Falls/head injuries:		

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Authorization

By signing this form, I understand that I am responsible to pay for any services rendered by the Cowichan Valley Chiropractic and Wellness Clinic which I have received. Unless otherwise negotiated, all services are cash/Debit, Visa, Mastercard, or American Express only.

_____ _____ _____

Signature Date Guardian (if applicable)