CONFIDENTIAL PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete all questions.
If you need help, please ask the receptionist. PLEASE PRINT

Name: _____ Date: _____

Address: _____

City: _____ Province_____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ MSP #:_____

Age: _____ Birth Date: _____ Marital Status: _____ No. of Children _____

Referred by: _____ Relationship: _____

Your Employer: _____ Occupation: _____ Years on Job: _____

Employer Address: _____

City: _____ Province: _____ Postal Code: _____

Office Phone: _____Do you have Extended Health Insurance? ☐ Yes ☐ No

Insurance Company: _____ Plan/Group #: _____

Name of Spouse or Parent: _____ Birth Date: _____

Spouse's Employer: _____Occupation: _____

Office Phone: _____ Cell Phone: _____

Describe The Major Complaints That Bring You To Our Office:

_____

_____

Is Your Condition Due To An Accident? ☐ Yes ☐ No Date of Accident: _____

Type of Accident? ☐ Auto ☐ Work/Job ☐ At Home ☐ Other: _____

ICBC Claim #_____ Adjuster's Name_____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be **met, arrangements must** be made in advance before seeing the doctor.

Patient's Signature: _____ *Date:* _____

Guardian's Signature (For Minors): _____*Date:* _____

HEALTH HISTORY

Name: _____

List All Current Health Problems: _____

_____

_____

List Any Other Doctors Seen, Treatments and Results Obtained: _____

_____

Your Current Physician(s) / Therapist(s): _____

_____

List All Surgeries And Their Dates: _____

_____

List Any Medications You Are Taking: _____

_____

List Any Traumas And Their Dates: _____

_____

Please Check The Conditions You Have Or Have Had:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ Chronic Fatigue
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Hypoglycemia
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Tuberculosis
- ☐ Venereal disease

Please Check All Present Symptoms:

CARDIOVASCULAR

- ☐ General swelling
- ☐ Swelling in legs
- ☐ Swelling in face
- ☐ Swelling around eyes
- ☐ Chest pain
- ☐ Pounding heart beat
- ☐ Rapid heart beat
- ☐ Irregular heart beat
- ☐ Blue or purple skin
- ☐ Blue or purple nail beds
- ☐ Cold hands / feet

VERTERBROBASILAR

- ☐ Double vision
- ☐ Loss of coordination
- ☐ Loss of memory
- ☐ Ringing in ears
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Muscle weakness
- ☐ Dizziness
- ☐ Blurred vision
- ☐ Stroke
- ☐ Hypertension
- ☐ Inability to form words
- ☐ Burning sensations
- ☐ Blindness
- ☐ Previous head injury
- ☐ Previous neck injury
- ☐ Taking birth control pills
- ☐ Family history of stroke
- ☐ Blood vessel disease
- ☐ Check if you smoke
- ☐ Fainting
- ☐ Area of numbness

HEALTH REVIEW

Please Check All Present Symptoms:

Skin, Hair, Nails
- ☐ Eczema
- ☐ Itchy skin
- ☐ Rough, scaly skin
- ☐ Dry skin
- ☐ Oily skin
- ☐ Yellow skin
- ☐ Bruise easily
- ☐ Baldness
- ☐ Paper thin nails
- ☐ Nail biting

Eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye fatigue
- ☐ Excessive tearing
- ☐ Lack of tearing
- ☐ Light bothers eyes
- ☐ Excessive itching
- ☐ Pain in eyeball

Ears
- ☐ Loss of hearing
- ☐ Not sufficient
- ☐ Pain in ears
- ☐ Discharge from ears
- ☐ Vertigo
- ☐ Ringing in ears

Nose & Sinuses
- ☐ Nose bleeds
- ☐ Pressure over eyes
- ☐ Nose obstruction
- ☐ Frequent colds
- ☐ Sinusitis
- ☐ Loss of smell
- ☐ Allergies

Mouth & Throat
- ☐ Pain in throat
- ☐ Bleeding gums
- ☐ Abscessed teeth
- ☐ Dentures
- ☐ Difficulty swallowing

Respiratory
- ☐ Shortness of breath
- ☐ Dry cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Productive cough

Gastrointestinal
- ☐ Poor appetite
- ☐ Constant nibbling
- ☐ Difficulty swallowing
- ☐ Indigestion
- ☐ Nausea & vomiting
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids

Genitourinary

Urination is
- ☐ Frequent
- ☐ Not sufficient

The amount is
- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Frequent urination at night
- ☐ Intense desire to urinate
- ☐ Difficulty urinating
- ☐ Lack of control
- ☐ Pain with urination
- ☐ Dribbling
- ☐ Bloody urine
- ☐ Cloudy urine

Venereal Disease
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Other

Women Only
- ☐ Painful periods
- ☐ Spotting
- ☐ Premenstrual symptoms
- ☐ Irregular periods
- ☐ Lumps in breast
- ☐ Vaginal discharge

# of pregnancies_____

# of deliveries_____

Social History
- ☐ Smoking
- ☐ Other tobacco use
- ☐ Alcohol use
- ☐ Drink coffee or tea

Diet is
- ☐ Balanced
- ☐ Not balanced

Rest is
- ☐ Sufficient
- ☐ Not sufficient

Recreation is
- ☐ Sufficient
- ☐ Not sufficient

Family stress is
- ☐ Severe
- ☐ High
- ☐ Moderate
- ☐ Minimal
- ☐ None

My job stress is
- ☐ Severe
- ☐ Moderate
- ☐ Minimal
- ☐ None

Other
- ☐ Nervousness
- ☐ Irritability
- ☐ Fatigue
- ☐ Depression
- ☐ Panic attacks
- ☐ Problems sleeping
- ☐ Generally feel run-down

MUSCULOSKELETAL SYSTEM

Please Check All Present Symptoms:

Head
- ☐ Frequent headaches
- ☐ Severe headaches
- ☐ Head feels heavy
- ☐ Vertigo
- ☐ Dizziness
- ☐ Light headedness
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Loss of hearing
- ☐ Loss of balance

Neck
- ☐ Pain in neck
- ☐ Pain with movement
- ☐ Swelling in neck
- ☐ Stiffness in neck
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Limited neck movement

Mid-Back
- ☐ Mid-back pain
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing pain
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Pain over kidney area
- ☐ Muscle spasms

Lower Back
- ☐ Lower back pain
- ☐ Lower back feels out of place
- ☐ Muscle spasms

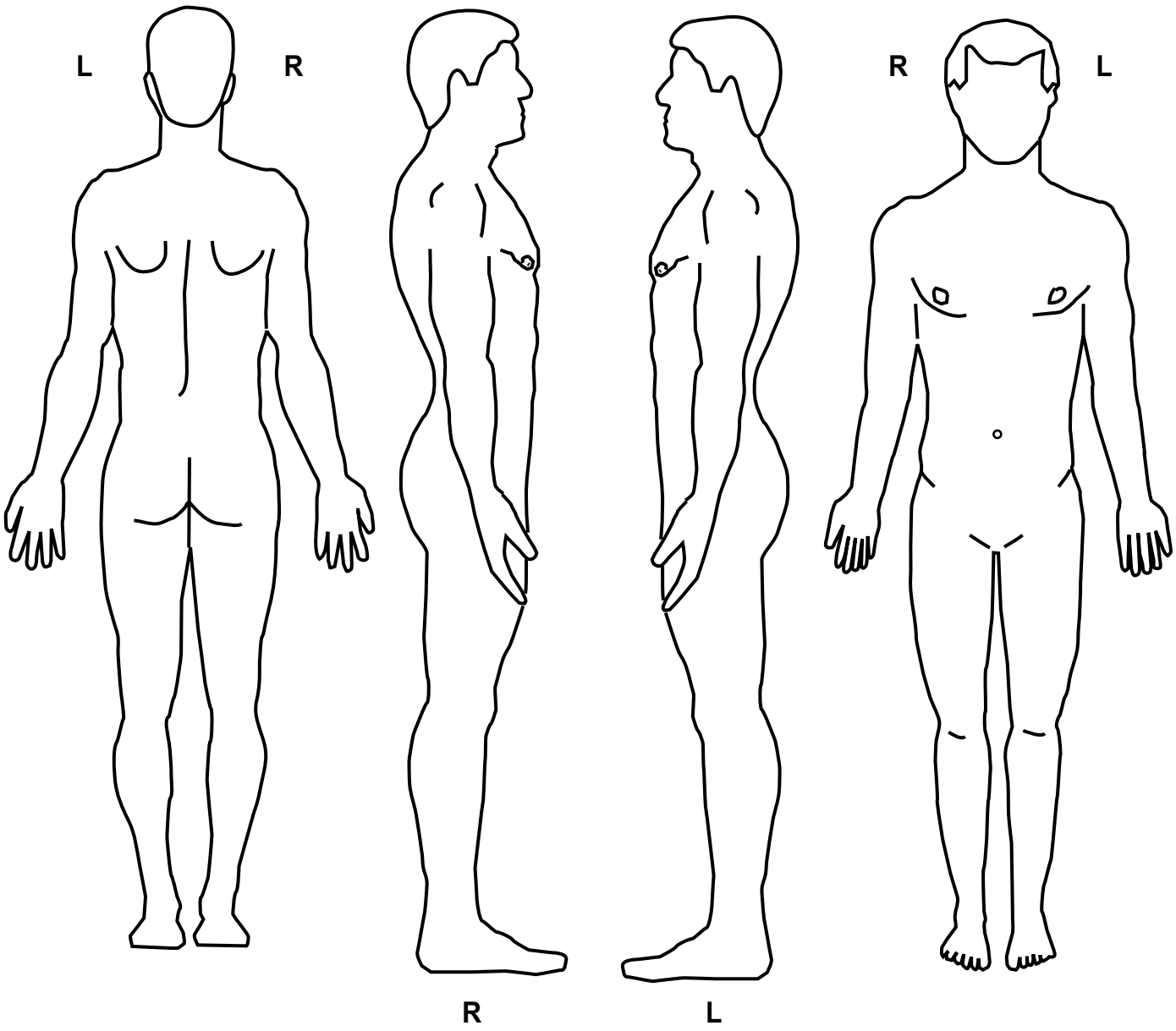
Shoulders
- ☐ Pain in shoulders
- ☐ Pain across shoulders
- ☐ Muscle spasms
- ☐ Can't raise arm
- ☐ Above shoulder
- ☐ Above head

Arms & Hands
- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Pins & needles
- ☐ In arms
- ☐ In fingers
- ☐ Fingers go to sleep
- ☐ Cold hands
- ☐ Swollen fingers
- ☐ Loss of grip strength

Hips, Legs & Feet
- ☐ Pain in buttocks
- ☐ Pain in hip
- ☐ Pain down leg
- ☐ Knee pain
- ☐ Leg cramps
- ☐ Pins & needles in legs
- ☐ Numbness in legs
- ☐ Numbness in toes
- ☐ Cold feet
- ☐ Swollen ankles
- ☐ Swollen feet

PAIN DRAWING

Name _____ **Date** _____



Mark as follows:
A - Ache B - Burning N - Numbness P - Pins & Needles
S - Stabbing O - Other - Describe _____