CONFIDENTIAL CASE HISTORY

PERSONAL INFORMATION: Date: _____

Last Name _____ First Name _____
Do you prefer: ☐ First name ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. Other_____
Address _____ City _____ Prov._____Postal _____
Home Ph. _____ Cell _____
E-Mail Address_____ I consent to receive correspondence via email initial ☐
Birth date; M: _____ D: _____Y: _____ Age _____Marital Status: ☐M ☐ S ☐W ☐ D
Occupation _____ Employer _____Telephone_____
Spouse's Name _____ Children's Name _____
What occupies your spare time? _____
Who referred you to our office? _____
Type of Coverage: ☐ MSP ☐ WCB ☐ ICBC ☐ other: _____
B.C. Care Card Number: _____

HEALTH INFORMATION:

Medical Doctor's Name: _____
Have you had previous chiropractic care? ☐ yes ☐ no When? _____ Why? _____
Have you ever had x-rays? ☐ yes ☐ no for what reason? _____
What is your major complaint? _____
How long have you had this condition? _____ Have you had it before? ☐ yes ☐ no
What aggravates your condition _____
Is it getting: ☐ Better ☐ Worse ☐ Constant ☐ Comes and goes
Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other _____
How long has it been since you really felt good? _____
Others who treated this condition: _____
List surgical conditions and years: _____
Drugs you now take: ☐ Pain killers☐ Muscle relaxants☐ Birth control☐ Vitamins☐ Other _____
Are you wearing: ☐ Heel lifts ☐ Orthotics ☐ Special supports or braces
Have you ever been in an automobile accident? ☐ Never ☐ Past year ☐ Within 5 years
☐ More than 5 years ago
Describe: _____
Have you ever had any other personal injury or accident? ☐ yes ☐ no Describe: _____

REASON FOR CONSULTING THE OFFICE:

☐ I have a specific problem and only require help with this problem.
☐ After my problem has been relieved, I am interested in strategies to ensure the problem does not return.
☐ Spinal checkup and to improve my general health.

HEALTH HISTORY:

To provide us with a more complete clinical picture, please answer the following questions, even if you do not think they are related to your health problem.
Pain is often referred from other areas or it may be related to a more serious underlying pathology.

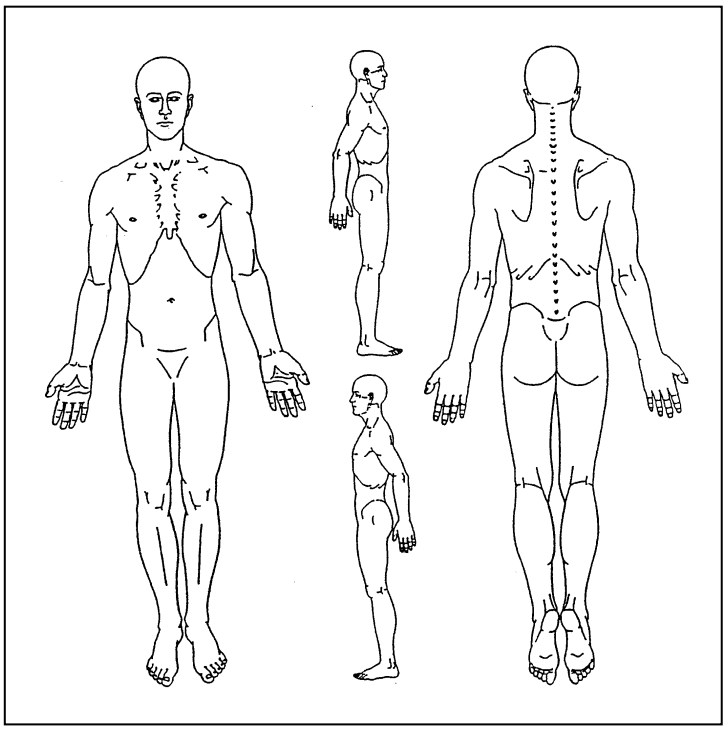
Have you ever suffered from:

1. Dizziness ☐ Yes ☐ No
2. Heart trouble ☐ Yes ☐ No
3. Diabetes ☐ Yes ☐ No
4. Arthritis ☐ Yes ☐ No
5. Asthma ☐ Yes ☐ No
6. Cancer ☐Yes ☐ No
7. Digestive problems ☐Yes ☐ No
8. Numbness ☐ Yes ☐ No
9. Tingling ☐ Yes ☐ No
10. Bladder trouble ☐ Yes ☐ No
11. Kidney trouble ☐ Yes ☐ No
12. Backaches ☐ Yes ☐ No
13. Neck pain ☐ Yes ☐ No
14. Headaches ☐ Yes ☐ No

FEMALES:

1. Severe menstrual pain ☐ Yes ☐ No
2. Vaginal pain ☐ Yes ☐ No
3. Breast pain ☐ Yes ☐ No
4. Lumps on breast ☐ Yes ☐ No

Please mark the main areas of pain on the figures below:



FAMILY HEALTH INFORMATION (Past or present health problems)

Mother: _____

Father: _____

Siblings: _____