Confidential Health Care History

303 - 2083 Alma Street, Vancouver, BC V6R 4N6

Name: _____ **Date:** _____

Address: _____

(Street) *(City)* *(Prov.)* *(Postal Code)*

Birthdate: d_____/m_____/y_____ **Age:** _____**Occupation:** _____

Phone Home: _____ **Cell #:** _____ **Work #:** _____

Email Address: _____ **Receive news and updates via email? Y N**

Family Doctor: _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

How did you hear about us? _____

What is your main area of concern? _____

When did the problem begin? _____

What treatments have your tried? ☐ Chiropractor ☐ Physiotherapist ☐ Naturopath ☐ Acupuncture

What makes it better?_____Worse?_____

Have you had this problem in the past? ☐ Yes ☐ No

If you have had any of the following, please describe briefly:

Surgery_____ Accidents _____

Bone fractures _____Illnesses _____

Energy levels: During daytime _____ Afternoon _____Evening _____

Stress level: ☐ None ☐ Slight ☐ Moderate ☐ Severe

Physical activity: ☐ None ☐ Low ☐ Moderate ☐ High

Please list any current medications:_____

Nutritional supplements or herbs: _____

Habits:

☐ smoking____packs/day, ☐ alcohol____drinks/week, ☐ coffee____cups/day, ☐ water____cups/day

Is there anything else you wish to let us know in regards to yourself?

_____

_____

_____

_____

Please check all that apply.

General:
- ☐ Hemophilia
- ☐ Bruise easily
- ☐ Edema
- ☐ Fatigue
- ☐ Heart disease
- ☐ AIDS/HIV
- ☐ Cancer
- ☐ Tumor
- ☐ Low/high blood pressure
- ☐ Diabetes
- ☐ Other _____

Digestion:
- ☐ Heartburn
- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Anorexia
- ☐ Bulimia
- ☐ Irritable Bowel Syndrome
- ☐ Hiatus hernia
- ☐ Gas
- ☐ Bloating
- ☐ Constipation
- ☐ Loose stools
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Other _____

Sleep:
- ☐ Hours of sleep per night
- ☐ Quality of sleep
- ☐ Wake up at night
- ☐ Difficulty falling asleep
- ☐ Easy falling asleep
- ☐ Light sleeper
- ☐ Deep sleeper
- ☐ Wake up rested
- ☐ Nightmares
- ☐ Frequent dreams
- ☐ Other_____

Gynecological:

# of pregnancies _____
# of births _____
# of therapeutic abortions ____
Age of 1st menses_____
Duration of menses_____
Age of Menopause _____
Last date of PAP_____
Birth Control _____

- ☐ Irregular periods
- ☐ Light periods
- ☐ Heavy periods
- ☐ Clots
- ☐ Painful periods
- ☐ Vaginal pain
- ☐ Fibroids
- ☐ PMS
- ☐ Endometriosis
- ☐ Infertility
- ☐ Other _____

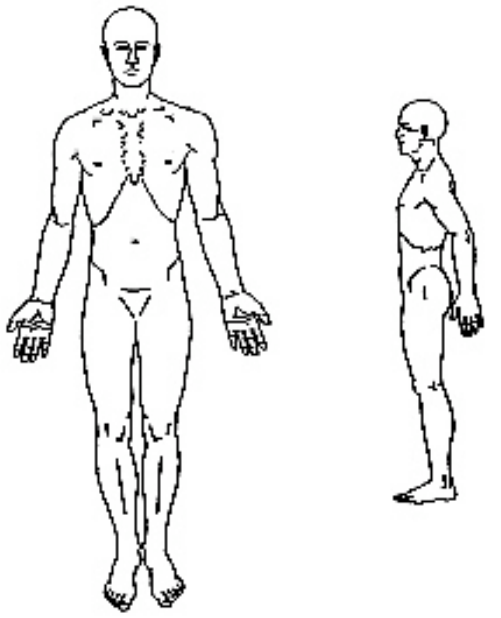
E/E/N/T:
- ☐ Ringing in ears
- ☐ Dizziness
- ☐ Earache/discharge
- ☐ Blurry vision
- ☐ Spots in front of eyes
- ☐ Eye dryness/pain
- ☐ Nose bleeds
- ☐ Recurrent sore throat
- ☐ Swollen glands
- ☐ Other _____

Musculoskeletal:
- ☐ Headaches
- ☐ Migraines
- ☐ Twitching of muscles
- ☐ Frequent backache
- ☐ Sore or aching joints
- ☐ Repeated strains
- ☐ Disc problems
- ☐ Other _____

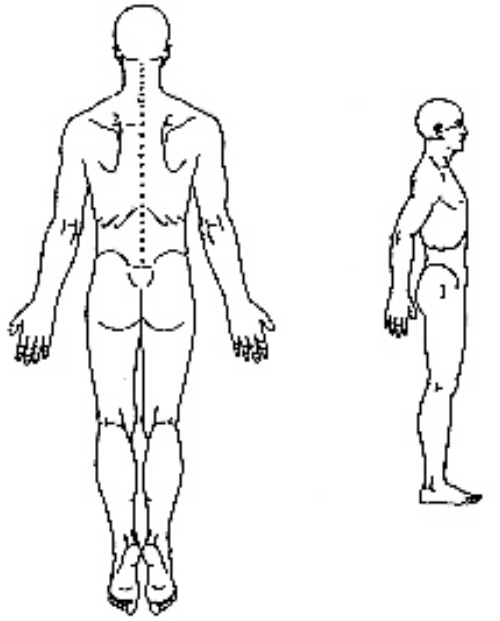
Genito-urinary:
- ☐ History of bladder/kidney infections
- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Decrease in urinary flow
- ☐ Unable to hold urine
- ☐ Incontinence at night
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Change in sexual drive
- ☐ Prostate issues
- ☐ Impotency
- ☐ Do you wake up to urinate?
- ☐ How many times? _____
- ☐ Other _____

Respiratory:
- ☐ Asthma
- ☐ Frequent cough
- ☐ Previous pneumonia
- ☐ Previous bronchitis
- ☐ Frequent chest colds
- ☐ Chronic sinus issues

Neurological:
- ☐ Previous stroke
- ☐ Paralysis
- ☐ Poor balance
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Irritability
- ☐ Aggressive/bad temper
- ☐ Anxiety
- ☐ Depression
- ☐ Panic attacks
- ☐ Other _____



INDICATE THE LOCATION OF CONCERN OR PAIN



In consideration of fellow patients and therapists, I understand that I will be charged the **full treatment fee** if I do not give **24 hours** notice of a change or cancellation of appointment.

By my signature below, I authorize the collection, use and disclosure of personal information, as defined in the Personal Information and Protection Act (PIPA), required for treatment and/or any related administrative purpose. I understand that all my personal information is confidential, and must be treated in accordance with PIPA

Signature: _____Date: _____