CONFIDENTIAL CASE HISTORY

WELCOME TO DISCOVER CHIROPRACTIC FAMILY WELLNESS CENTRE

THE IMPORTANCE OF THIS FORM AND YOUR PRIVACY **DATE:** ______________________

This information will be used to assist the doctor in making the best choices for your examination AND for deciding how chiropractic care can best help you. Please answer all questions and when there are "none" or "non-applicable" please indicate. The information collected **will be kept confidential** and will only be used for clinical purposes. It **WILL NOT** be shared with anyone else without YOUR express permission.

Care Card PHN# ________________ Last Name ______________________ First Name ____________________

Birth date (M/D/Y) _________________ Age _____ Female ____Male ____ Occupation____________________

Address __________________________________ City __________________ Postal Code ________________

Home Phone _____________ Work Phone _______________ Email Address ______________________________

Name of Spouse _____________________ Names/ages of children_____________________________________

Name and number of Emergency Contact ____

How did you find out about our office? ____

If you were referred to our office, whom may we thank? ____

STOP!! PLEASE READ!!! The purpose of today's visit is to provide the most complete physical examination most people have ever had. **ONLY in EXCEPTIONAL circumstances will any adjustments be performed** prior to your file being carefully analyzed and the findings presented (usually on your next visit). This approach is consistent with any significant health-related procedure. You will find that the two things we never compromise are YOUR HEALTH and OUR REPUTATION.
The fee for today's examination is $50. If you strongly desire an adjustment and the doctor determines that is acceptable to do so, the regular adjustment fee of $40 will be added to the examination fee. (**Total fee = $90**)

PLEASE INITIAL HERE indicating that you have read and understand this section:
____

CURRENT AND PAST BODY SIGNALS INDICATING UNDERLYING DYSFUNCTION

Please indicate which of the following body signals apply (use "C" for current and "P" for previous):

☐ Headaches	☐ Back Pain	☐ Neck Pain	☐ Pins/Needles in Arms/Leg
☐ Shoulder Pain	☐ Stress	☐ Muscle Tension	☐ Overall Joint Pain/Stiffness
☐ Difficulty Walking/Sitting	☐ Difficulty Driving	☐ Difficulty Working	☐ Difficulty Lifting/Bending
☐ Weakness	☐ Loss of Balance/Dizziness	☐ Fatigue	☐ Loss of Coordination
☐ Frequent Colds/Flu	☐ Ringing in Ears	☐ Sinus Problems	☐ Diarrhea/Constipation
☐ Indigestion	☐ Sleeping Problems	☐ Allergies	☐ Asthma
☐ Anxiety	☐ Depression	☐ Moody/Irritable	☐ Lack of Concentration
☐ High Blood Pressure	☐ Vision Problems	☐ Poor Memory	☐ Menopausal Difficulties
☐ Fertility Dysfunction	☐ Prostate Dysfunction	☐ Sexual Dysfunction	☐ Menstrual Difficulties

Are any of your friends or family suffering from any of these dangerous body signals? **Yes** ☐ **No**☐
If so, who? ____

Have you been under chiropractic care before? **Yes** ☐ **No** ☐ What was the date of your last visit? _________

Was your experience positive, negative or neutral? _______________ Why? _______________________________

Do you wear orthotics or special shoe inserts? **Yes** ☐ **No** ☐ How old are they? _________________________

REASON FOR YOUR VISIT

Is this a WCB Case? (work related injury)	Yes ☐ (see form WCB)	No ☐
Is this an ICBC Case? (motor vehicle accident)	Yes ☐ (see form ICBC)	No ☐

What brought you into our office/What is your main concern? ____

When did the first symptom of this underlying dysfunction arise? ____

Have you had this problem before? Yes ☐ No ☐

Is there a specific event that caused your current concern? (describe)______________________________________

Are your symptoms: ☐ Constant ☐ Intermittent ☐ Daily

Do your symptoms stay in the same place or do they radiate? If so, where? _______________________________

What is the intensity of your pain/symptoms on a scale of 1 to 10? (10 being the worse) ______________________

Describe the character of your pain/symptoms (dull, achy, sharp, throbbing, numbness etc) ___________________

What aggravates your symptoms? ____

What relieves your symptoms? ____

Anything associated with your pain/symptoms? (wake you at night, problem urinating, fever etc)_______________

Does this problem interfere with: ☐ Work ☐ Sleep ☐ Daily routine ☐ Moods

Are your problems: ☐ getting worse ☐ getting better ☐ staying the same

Other Doctors/Therapists that have treated this condition ____

What treatments were given? ____

Were X-rays taken? ____

Do you have any other concerns?____

Have you ever had surgery? Yes ☐ No ☐

Describe ____

Have you been diagnosed with any medical conditions? Yes ☐ No ☐

Describe ____

Are you now using or have you ever used prescription drugs? Yes ☐ No ☐

Describe **PAST**____

CURRENT____