



CONFIDENTIAL CASE HISTORY

Date: _____

PERSONAL INFORMATION:

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 _____
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:

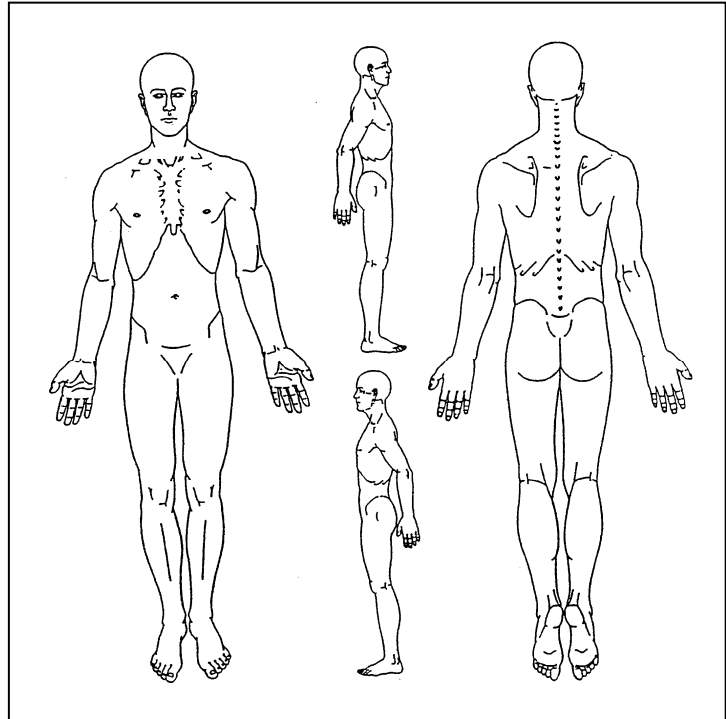
To provide us with a more complete clinical picture, please answer the following questions, even if you do not think they are related to your health problem.

Pain is often referred from other areas or it may be related to a more serious underlying pathology.

Have you ever suffered from:
on the figures below:

- | | |
|-----------------------|--|
| 1. Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Heart trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Digestive problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Numbness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Tingling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Bladder trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Kidney trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Backaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Neck pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please mark the main areas of pain



FEMALES:

- | | |
|--------------------------|--|
| 1. Severe menstrual pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Vaginal pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Breast pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Lumps on breast | <input type="checkbox"/> Yes <input type="checkbox"/> No |

FAMILY HEALTH INFORMATION (Past or present health problems)

Mother: _____

Father: _____

Siblings: _____