

WESTSIDE CHIROPRACTIC & ASSOCIATES

1430 W.7TH AVE, VANCOUVER BC, V6H 1C1 604-738-2503

Please print clearly

Name: _____	Care Card #: _____	Date: _____
Street address: _____	Phone Number: (____) _____	Age: _____
City: _____	Other Phone: (____) _____	Gender: _____
Postal Code: _____	Fax: (____) _____	Occupation: _____
Birthday(M/D/Y): _____		Employer: _____
Email: _____ <small>(this is used for follow-up only and will not be given out)</small>	Marital Status: Married Single Widowed Common-Law	# of Children: _____
Is this an ICBC Case? Yes No	Is this a WCB Case? Yes No	Name of Current Medications: _____
Name of MD: _____		

Have you previously seen a: Chiropractor Acupuncturist Massage therapist Physiotherapist	Name of Practitioner(s): _____ Last visit: _____ Number of visits: _____	What were the results?: _____ _____
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❖ Whom may we thank for referring you?: _____

GOALS FOR CARE: (check one)

- I am only interested in help with this specific problem.
- I am interested in help with this problem AND learning how to prevent it in the future.
- I have no specific problem, and I understand the role that chiropractic care has on my well-being.

CASE HISTORY:

Describe your main complaint: _____

When and how did your problem begin? _____

Is this a new condition? Yes No

Please indicate on the diagram anywhere you experience pain, numbness, tingling, or weakness:

How would you describe your pain? (check all that apply)

- | | | |
|--------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Achy |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> Constant | <input type="checkbox"/> On and Off |



Rate your current level of pain: (1 = NO PAIN, 10 = MAXIMUM PAIN)

1 2 3 4 5 6 7 8 9 10

Have you noticed anything that makes your condition worse? _____

Have you found anything that relieves your symptoms? _____

Doctor's Notes:

PAST HEALTH HISTORY – Please check all that apply, (P) past or (C) current.

P	C		P	C		P	C	
		Allergies			Headaches			Sleeping problems
		Arthritis			Heart problems			Stress
		Asthma			High blood pressure			Stroke
		Bladder/urination problems			Insomnia			Surgery _____
		Cancer			Leg pain			Swelling
		Car Accident			Low back pain			Thyroid problems
		Chest pain			Mental illness			TMJ problems (jaw tension)
		Constipation (chronic)			Mid back pain			Unexplained weight loss
		Depression			Nausea (chronic)			X-rays
		Diabetes			Neck pain			Other past injuries/falls
		Diarrhea (chronic)			Nighttime pain			Other: _____
		Digestive difficulties			Numbness/tingling			
		Disc injury			Osteoporosis			Women:
		Ear problems			Poor posture			Anemia
		Epilepsy			Sciatica			Painful Menstruation
		Eye problems			Scoliosis			Irregular Menstruation
		Fainting			Shortness of breath			Heavy Menstrual Bleeding
		Fracture			Shoulder problems			Menopause
					Skin problems			Pregnancy (# of) ____

HABITS AND LIFESTYLE:

How many hours do you sleep a typical night? _____ Do you feel rested? Yes No

<input type="radio"/> Vegan	<input type="radio"/> MANY fruits and vegetables	<input type="radio"/> Red meat	<input type="radio"/> High carbohydrate/ High sugar diet
<input type="radio"/> Vegetarian	<input type="radio"/> FEW fruits and vegetables	<input type="radio"/> Chicken and fish	<input type="radio"/> Whole Grains
<input type="radio"/> Low Sugar Diet	<input type="radio"/> Aspartame/artificial sweeteners	<input type="radio"/> Vitamins/ Supplements	<input type="radio"/> Celiac/Gluten Free

Please check the words that best describe your eating habits.

Are you satisfied with your current weight? **Yes / No**
 Do you feel the need to improve your posture? **Yes / No**
 Do you exercise regularly? **Yes / No** What type of exercise? _____
 How often? _____ x per week.

Do you drink: Coffee _____ cups/day Soft Drinks _____ cups/day
 Tea _____ cups/day Water _____ cups/day
 Alcohol _____ drinks/week

Do you smoke? _____ pack(s)/day
 How would you describe your stress level? **LOW / MEDIUM / HIGH**
 Is it manageable? **Yes / No**
 Do you take part in any meditation or relaxation exercises? **Yes / No** _____

FEES: First visit \$80 Regular Visit \$50 Re-exam \$55 Spinal Decompression \$45 Laser \$30

Name: _____ Signature: _____ Date: _____