WESTSIDE CHIROPRACTIC & ASSOCIATES

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

Please print clearly

Name:___________________________
Street address:_____________________
City:____________________
Postal Code:____________
Birthday(M/D/Y):_______________

Email:______________________________
(this is used for follow-up only and will not be given out)

Is this an ICBC Case? Yes No
Name of MD: ______________________

Care Card #:__________________
Phone Number:(___)_____________
Other Phone: (___)______________
Fax: (___)______________

Marital Status:
Married Single
Widowed Common-Law

Is this a WCB Case? Yes No

Date:_______________
Age:________
Gender:________
Occupation:________________
Employer:_________________

# of Children:_____

Name of Current Medications:

____

Have you previously seen a: Chiropractor, Acupuncturist, Massage therapist, Physiotherapist	Name of Practitioner(s): ________________________________ Last visit:___________________ Number of visits: ___________	What were the results?: _________________________ _________________________

❖Whom may we thank for referring you?: ____

GOALS FOR CARE: (check one)

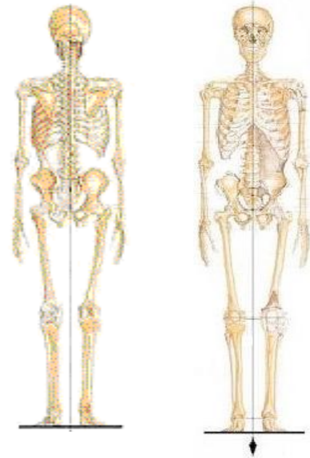
- ○ *I am only interested in help with this specific problem.*
- ○ *I am interested in help with this problem AND learning how to prevent it in the future.*
- ○ *I have no specific problem, and I understand the role that chiropractic care has on my well-being.*

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)

☐ Sharp ☐ Dull ☐Achy
☐ Stiff ☐ Constant ☐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

- Vegan
- Vegetarian
- Low Sugar Diet
- MANY fruits and vegetables
- FEW fruits and vegetables
- Aspartame/artificial sweeteners
- Red meat
- Chicken and fish
- Vitamins/ Supplements
- High carbohydrate/ High sugar diet
- Whole Grains
- 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
Tea _____ cups/day
Alcohol _____ drinks/week
Soft Drinks ____ cups/day
Water ____ cups/day

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** ______________________

Name:_________________________ Signature:_________________________ Date:____________