

glover road chiropractic & sports therapy

#203 – 5755 Glover Road
Langley, BC V3A 8H4
604-533-3033

Welcome to our Office!

Patient Questionnaire

- This is an important first step in communicating the purpose of your visit. All information is confidential. PLEASE COMPLETE ALL QUESTIONS ON THE NEXT 2 PAGES

Consultation

- Please inform the Doctor the reason for your visit, outlining, in detail, your related health concerns. Providing the most accurate information as possible related to your condition will greatly assist us in recommending the most effective treatment program.

Examination

- Diagnostic chiropractic, orthopaedic, and neurological examination procedures will be performed to determine the cause of your condition.

Report of Findings

- The Doctor will advise you of his findings and diagnosis and recommend treatment options to assist in your recovery. Freely ask questions. It is important that you clearly understand the results of your assessment and that you are committed to participating in a successful treatment program.

Types of Care

- Relief care – Reduction of symptoms such as pain, inflammation and limited motion.
- Corrective care – Restoration of normal, healthy body functions. Correcting the underlying cause.
- Maintenance care – Support of ongoing healing and helps prevent future health problems.

Re-Evaluations

- At the conclusion of each phase of your Treatment Program you will receive a re-assessment to evaluate your progress.

Exercise Programs

- To obtain optimal results it is important that you participate fully in recommended exercise programs.
- All patients will receive a personalised computer printout of *Phases* exercise program designed specifically for you. All exercises are designed after assessing your specific requirements and are periodically re-evaluated throughout your care.

Patient Education

- Throughout your Treatment program you will be provided with patient education material to assist you in understanding the long-term benefits of chiropractic health care

We appreciate you taking the time to provide this confidential information. Please be assured that we will do everything possible to assist you in your recovery.
Thank you for your cooperation.

CONFIDENTIAL PATIENT HEALTH RECORD

Please circle or describe

Date: _____

Name: _____

File # : _____

Birth Date: (M/D/Y) _____ Age: _____

Care Card #: _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Employer: _____

Type of Work: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Would you like to receive Electronic Newsletters/Office updates ? Yes No

Extended Insurance? Yes No Name of Insurance Carrier: _____

Is this visit the result of a Motor Vehicle Accident or Worker's Compensation Injury? Yes No

If yes, please advise the receptionist

CONFIDENTIAL HEALTH HISTORY

- Previous Chiropractic Care (Dr.'s name and date of last treatment): _____
- Family Dr.: _____ Referred to Office by: _____
- Purpose of this appointment (Primary Complaint): _____
- When did this condition begin? _____
- Is your condition getting better, worse or staying the same? _____
- What aggravates your condition? _____
- What relieves your condition? _____
- Are there others in your family with this same condition? Yes No
- Have you seen any other health care practitioner for this condition? Yes No
- If yes, Who? _____
- Have you ever had any major illnesses? Yes No
- If yes, please specify _____
- Current Medications: _____
- For what conditions? _____
- Current Vitamins/Minerals/Herbal supplements: _____
- Major surgery or operations? _____
- Major accident or falls? _____
- Family History of illness or disease? _____
- Previous X-rays or special Imaging (MRI, CT, Bone Scan)? Yes No If yes, what body part? _____

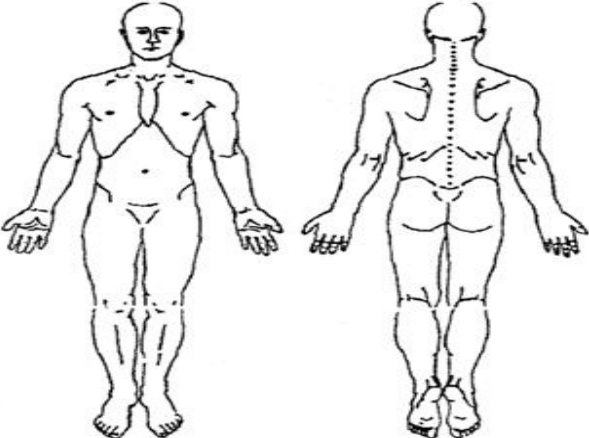
- Type of care you are seeking today? ___ Symptom Relief ___ Corrective Care ___ Maintenance Care

Females Only

- When was your last period _____ Are you pregnant? Yes No If yes, due date: _____
- Have you ever been pregnant? Yes No If yes, # of children: _____ C-Section Yes No
- Are you menopausal? Yes No

Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these symptoms can affect your overall course of Chiropractic Care.

CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU HAVE HAD IN THE PAST 6 MONTHS

<p>MUSCULO-SKELETAL</p> <ul style="list-style-type: none"> • Low back/sciatic pain • Hip pain • Knee pain • Ankle pain • Foot pain • Walking problems • Joint pain/ stiffness • Headache • Neck pain • Jaw/TMJ pain – clicking • Pain between shoulders • Shoulder/ rib pain • Elbow/ wrist pain • Arm/ hand pain 	<p>NERVOUS SYSTEM</p> <ul style="list-style-type: none"> • Stress • Nervous • Paralysis • Convulsions • Dizziness • Forgetfulness • Confusion • Depression • Epilepsy • Fainting • Numbness • Cold/tingling extremities • Muscle spasm • Muscle weakness 	<p>GASTRO-INTESTINAL</p> <ul style="list-style-type: none"> • Poor/excessive appetite • Excessive thirst • Frequent nausea • Vomiting • Diarrhea/constipation • Hemorrhoids • Liver problems • Gall bladder problems • Ulcers • Abdominal cramps • Gas/bloating after meal • Heartburn • Colitis
<p>GENITO-URINARY</p> <ul style="list-style-type: none"> • Bladder trouble • Painful/excessive urination • HIV/AIDS 	<p>PLEASE OUTLINE ON THE DIAGRAM YOUR AREA(S) OF PAIN</p> <div style="text-align: center;">  </div>	
<p>CARDIOVASCULAR</p> <ul style="list-style-type: none"> • Chest pain • Shortness of breath • High/low blood pressure • Heart problems • Lung problems • Stroke 	<p>Please rate the severity of your pain (With 0 being no pain and 10 being unbearable pain):</p> <p style="text-align: center;">0 1 2 3 4 5 6 7 8 9 10</p>	
<p>EYES, EARS, NOSE, THROAT</p> <ul style="list-style-type: none"> • Vision problems • Dental problems • Ear aches • Hearing difficulty • Smell/taste problems 	<p>GENERAL HEALTH INFORMATION</p> <ul style="list-style-type: none"> ○ How would you rate your stress level? Low Moderate High ○ How would you rate your activity level? Low Moderate High ○ Have you ever worn foot orthotics? Yes No ○ How many hours do you sleep at night? 0-4 4-6 6-8 8-10+ ○ Do you drink coffee on a regular basis? Yes No ○ Do you smoke? Yes No ○ Rate your alcohol consumption? None Low Moderate High ○ Do you take vitamins or minerals? Yes No ○ Are you interested in taking oral supplements: <ul style="list-style-type: none"> ○ Glucosamine/joint formula Yes No ○ High potency multivitamin Yes No ○ Natural anti-inflammatory Yes No ○ Omega 3/essential oils Yes No 	
<p>MALE/FEMALE</p> <ul style="list-style-type: none"> • Menstrual irregularity • Breast pain/lumps • Prostate/sexual dysfunction • Bowel/bladder control loss 		
<p>GENERAL</p> <ul style="list-style-type: none"> • Fatigue • Allergies • Loss of sleep 		
<p>Any other symptoms not listed:</p> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/>		