#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

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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

MUSCULO-SKELETAL
- 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

NERVOUS SYSTEM
- Stress
- Nervous
- Paralysis
- Convulsions
- Dizziness
- Forgetfulness
- Confusion
- Depression
- Epilepsy
- Fainting
- Numbness
- Cold/tingling extremities
- Muscle spasm
- Muscle weakness

GASTRO-INTESTINAL
- 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

GENITO-URINARY
- Bladder trouble
- Painful/excessive urination
- HIV/AIDS

CARDIOVASCULAR
- Chest pain
- Shortness of breath
- High/low blood pressure
- Heart problems
- Lung problems
- Stroke

EYES, EARS, NOSE, THROAT
- Vision problems
- Dental problems
- Ear aches
- Hearing difficulty
- Smell/taste problems

MALE/FEMALE
- Menstrual irregularity
- Breast pain/lumps
- Prostate/sexual dysfunction
- Bowel/bladder control loss

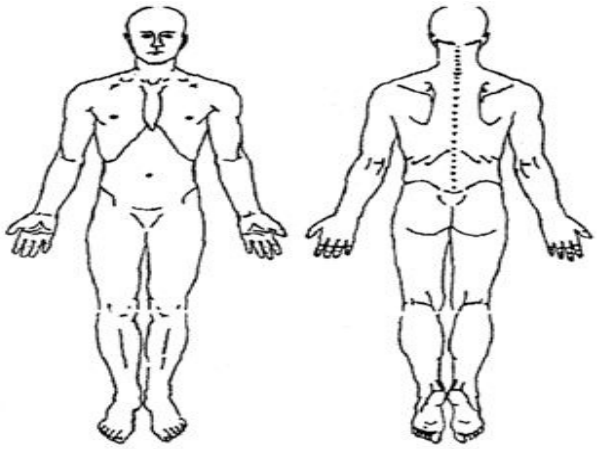
GENERAL
- Fatigue
- Allergies
- Loss of sleep

Any other symptoms not listed:

_____

_____

PLEASE OUTLINE ON THE DIAGRAM YOUR AREA(S) OF PAIN



Please rate the severity of your pain

(With 0 being no pain and 10 being unbearable pain):

0 1 2 3 4 5 6 7 8 9 10

GENERAL HEALTH INFORMATION

- 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:
  - Glucosamine/joint formula **Yes No**
  - High potency multivitamin **Yes No**
  - Natural anti-inflammatory **Yes No**
  - **Omega 3/essential oils** **Yes No**