## PERSONAL HISTORY

## **Dear Patient:**

Please complete this questionnaire. Your answers will help determine if Chiropractic can help you. Please answer ALL questions, even if they seem unrelated to your case. There are conditions Chiropractic can help that you may be unaware of. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name		Birthd	ate <b>dd/mm/yyyy</b>		Date					
BC Health Card #	····		Phone: (home)		(office)					
					(cell)					
Marital Status	Age		Weight	Height	Children					
CURRENT HEALTH CONDITION										
Reason for consulting this off	ice									
Have you had any previous tre	eatment for this	condition?								
When did this condition begin	?									
What do you believe caused the	nis condition?									
Are there others in your family										
What aggravates your condition? □ sitting □ standing □ bending □ lifting □ walking										
What relieves your condition?										
Have you had any time loss from work for this condition? (if recent, list dates)										
WCB Claim#		WC	B Adjuster name							
Are you presently taking any medications? (Please mention)  Have you had any x-rays taken in the past year?  If yes, where?										
Do you wear heel lifts or orthotics?										
Are you anxious about receivi										
		·····								
PAST HEALTH HISTORY										
Major surgery / operations:	<ul><li>□ Appendix</li><li>□ Heart</li></ul>	□ Tonsils □ Back	□ Gall Bladder □ Neck	□ Hernia □Leg	Other					
Major accidents or falls: (please	se describe)									
Previous Chiropractic Care: D	octor's name and	d approxima	te date of last visit							
Have you been treated for any	health condition	in the last y	/ear?							
TC1 1 *										
Family Physician		<del></del>	Pł	one						
Check any conditions which a	re presently caus	sing you a pr	oblem.							

Please underline which were a problem in the past. **GENERAL ORGANS** SKIN RESPIRATORY & HEART □ headache □ painful urination □ eczema □ lung problems

arms or legs   blood in urine   spit up blood   spit up blood	□ numbness o	r nain	_	frequent ur	ination	- 1:	□ lung problems	
distributes   bladder trouble   frequent colds/flu   frequent colds/flu   shortness of breath   difficult breathing   heart problems   pseud loysfunction   painful tailbone   heart problems   pseud loysfunction   painful tailbone   heart problems   pseud loysfunction   painful tailbone   heart problems   pseud loysfunction   painful tailbone   heart problems   pseud loss of weight				□ frequent urination		□ skin eruptions	□ chronic cough	
minging in ears	<ul><li>□ dizziness</li><li>□ ringing in ears</li><li>□ whiplash</li></ul>			<ul><li>□ bladder trouble</li><li>□ kidney stones</li><li>□ bed wetting</li></ul>		□ varicose veins		
Street   S						MICCIPA		
attining								
Servind						<u> </u>	difficult breathing	
□ nose bleeds □ thyroid □ pain between shoulders □ pain between shoulders □ pain between shoulders □ painful periods □ sinus problems □ asthma □ arthritis □ sore muscles □ irregular cycle □ class of weight □ gas/bloating □ broken bones □ constipation/diarrhea □ difficulty chewing/ □ liber trouble □ limb pain □ hot flashes □ pain between shoulders □ painful periods □ irregular cycle □ cramps, backache □ constipation/diarrhea □ difficulty chewing/ □ liber trouble □ limb pain □ hot flashes □ menopausal symptoms □ leartal problems □ liber trouble □ limb pain □ hot flashes □ and learning problems □ pail bladder trouble □ limb pain □ hot flashes □ and problems □ pain □ pain □ hot flashes □ and problems □ arthritis □ pain □ hot flashes □ and problems □ arthritis □ lalergies □ hat disease □ high blood pressure □ stroke □ arthritis □ hypoglycemia □ hepatitis □ thereulosis □ diabetes □ cancer □ allergies □ hemophilia □ H.I.V. /AIDS    Abactic						_		
Sinus problems	□ sore throat □ anemia □ nose bleeds □ thyroid □ sinus problems □ asthma □ enlarged glands □ excessive ap □ loss of weight □ gas/bloating			□ anemia □ thyroid			FEMALES ONLY  painful periods	
sinus problems								
class of weight   class of w						•		
cramps, backache   mauses or vomiting   mauses or				nnatita				
nausea or vomiting   nausea or vomiting   nausea or vomiting   nervousness   nausea or vomiting   nervousness								
constipation/diarrhea   difficulty chewing/ clicking jaw   previous miscarriage   notes   clicking jaw   previous miscarriage   notes   note								
dental problems	□ nervousness					- · · · - <del>-</del>		
class of problems	_						□ menopausal symptoms	
dental problems	. <del>-</del> .	•					□ previous miscarriage	
hearing problems								
Check any of the following diseases you have had:    alcoholism						•		
Check any of the following diseases you have had:  □ alcoholism □ epilepsy □ stroke □ arthritis □ hypoglycemia □ hepatitis □ high/low blood pressure □ osteoporosis □ respiratory conditions □ osteoporosis □ respiratory conditions □ ostroke □ arthritis □ heart disease □ high/low blood pressure □ osteoporosis □ high blood pressure □ stroke □ cancer □ arthritis □ diabetes  HABITS Please outline on the diagram The area of your discomfort.  Exercise □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □			- 7	5411 O144401	a oubje	⊔ neck pain		
Check any of the following diseases you have had:    alcoholism								
alcoholism							when was your last period?	
□ osteoporosis □ respiratory conditions □ hemophilia □ H.I.V. /AIDS  Has anyone in your family had any of the following diseases? □ heart disease □ high blood pressure □ stroke □ cancer □ arthritis □ diabetes  other  HABITS Please outline on the diagram The area of your discomfort.  Exercise □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	□ alcoholism	□ alcoholism □ epilepsy □ stroke □ ar				J pog-Joonna	-	
Has anyone in your family had any of the following diseases?   heart disease	□ osteoporosis	□ re	spiratory	conditions			Inign/low blood pressure	
heart disease   high blood pressure   stroke   cancer   arthritis   diabetes      HABITS   Please outline on the diagram	•			001101110110		iopinia   H.I.V./AIDS		
heart disease   high blood pressure   stroke   cancer   arthritis   diabetes      HABITS   Please outline on the diagram	Has anyone in v	our family	v had anv	of the follo	wina di	-0		
The area of your discomfort.    Stress	□ heart disease	n high b	slood mad		_			
HABITS    None   Light   Moderate   Heavy   The area of your discomfort.   Exercise		- mgn c	nood pres	sure 🛮 St	roke	cer   arthritis   diabetes		
None Light Moderate Heavy The area of your discomfort.  Exercise								
None Light Moderate Heavy The area of your discomfort.  Exercise		HA	TRILLS			Please outline o	use outline on the diagram	
Sleep		None	Light	Moderate	Heavy	The area of you	r discomfort.	
Coffee	Exercise					_		
Coffee	Sleep					25	<u> </u>	
Tobacco Alcohol Junk Food Stress Do you take any vitamins, minerals or herbal products?  Do you play / participate in any sports?  IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? (Local and/or closest relative)  Name: 1) Phone:	Coffee		п	_		$\left( \left\langle \hat{n},\hat{n}\right\rangle \right)$		
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Alcohol		_				//	//\.\\\	
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Phone:	Name: 1)	·TIKODINC	, who	SHOULD	WE CO	CI? (Local and/or closest relative	re)	
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