ActiveLiving
chiropractic

p: 250.448.8008
f: 250.448.7428

565 Osprey Avenue
Kelowna, BC V1Y 5A7
www.kelowna-chiro.com

Name ______________________________

Birthdate ________________(month / day / year)

Address ______________________________

____

Postal Code ______________________________

Phone (home) ____________________

(cell) ____________________

(work) ____________________

Email ____________________

Occupation ____________________

How did you hear about our clinic? □Friend:_________

□Yellow Pages □Sign □Website □Other:___________

Do you currently wear orthotics? □Yes □No

Are you interested in gait analysis? □Yes □No

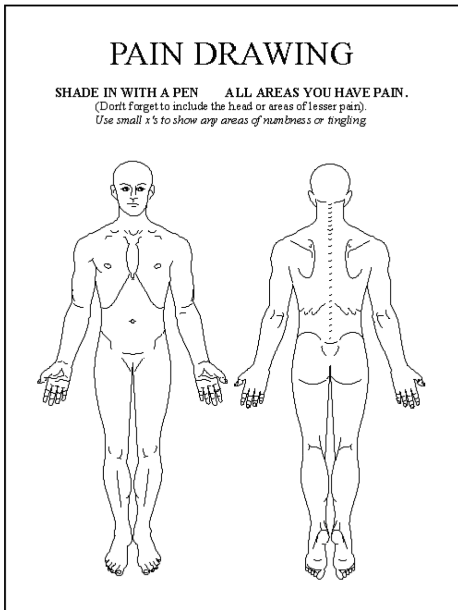
Care Card # ____________________

Extended Medical Insurer ____________________

ICBC or **WCB?** **No Yes** Claim#

(if active claim, please inform Practitioner as you will need to fill out the related Claim Form)

CURRENT CONDITION:



Please describe your current condition & symptoms:______________________

____

How long have you had this condition/symptom?______________________

Have you had this condition before? YES NO **When**?:____________

What makes it **better** (positions/activities/movements)?______________________

What makes it **worse(**positions/activities/movements)?______________________

What % of each day does it **bother you**? (Circle one)

0% 25%(Intermittent) 50%(Occasional) 75%(Frequent) 100%(Constant)

Does this **affect you** at:

Work Play/Activities/Exercise Sleep Romance/Love life

Please mark on the line, the pain level that most accurately represents your pain for **each** body area:

	0	1	2	3	4	5	6	7	8	9	10	
Average pain:	No pain	|	|	|	|	|	|	|	|	|	|	Unbearable

GOALS FOR CARE: Check all that apply

□ RELIEF I want to feel better for the least amount of my time and money.
□ CORRECTION I want to stabilize and retrain the muscles and ligaments of my spine and skeletal system.
□ MAINTENANCE I want to preserve the progress I've made
□ PREVENTION I want to avoid losing my health
□ WELLNESS I want to be all that I can be, high quality performance, sleep, energy, immune system, maximum brain power and more.

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PERSONAL HEALTH HISTORY - The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

GENERAL CURRENT CONDITIONS

- ☐ **Recent accident** such as a fall, whiplash, or blow to the head
- ☐ Spinal/back/neck problems
- ☐ Muscle spasms
- ☐ Restricted movement
- ☐ Numbness or tingling of hands or feet or radiating pain
- ☐ Headaches or Migraines
- ☐ Sinus problems
- ☐ Nausea
- ☐ Depression
- ☐ Anxiety or difficulty with stress
- ☐ Dizziness or vertigo
- ☐ Vision problem
- ☐ Hearing problem
- ☐ Sleeping trouble
- ☐ Asthma or breathing problem
- ☐ Digestive trouble
- ☐ Heartburn/Acid Reflux
- ☐ Menstrual problems
- ☐ Jaw or mouth problem
- ☐ Arm, shoulder, elbow or hand problem
- ☐ Leg, hip, knee or foot problem

DIAGNOSED CONDTIONS

- ☐ Born with bone or joint disorder
- ☐ Osteoporosis
- ☐ Degenerative arthritis/Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Compression fracture
- ☐ Heart attack or heart disorder
- ☐ History of stroke or aneurysm
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Lupus
- ☐ Ankylosing spondylitis
- ☐ Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
- ☐ 3 or more months of steroid medications or intravenous drugs (past or present)
- ☐ Tuberculosis
- ☐ Hepatitis B or HIV infection
- ☐ Multiple sclerosis
- ☐ Thyroid or hormone disorder
- ☐ High blood pressure
- ☐ Convulsions/epilepsy
- ☐ OTHER:

SPECIFIC PAIN IN THE BODY

- ☐ Difficulty swallowing because of neck pain
- ☐ Pain or electric shocks in arms or legs when moving neck
- ☐ Leg pain worse with exercise
- ☐ Numbness of inner thighs
- ☐ Back pain with urinary problems
- ☐ Severe pain that interrupts sleep
- ☐ Constant pain that doesn't improve by changing positions or by lying down

SPECIFIC CURRENT CONDITIONS

- ☐ Poor balance
- ☐ Loss of bowel or bladder control
- ☐ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ☐ Memory loss after injury
- ☐ Recent, unexplained weight loss
- ☐ Recent progressive muscle weakness or shaking
- ☐ Recent or current fever over 102°F

Describe any **surgeries** / hospitalizations / motor vehicle accidents / sporting accidents / personal/work accidents / fractures / dislocations / & / or illnesses you've had and the **dates**:____

____

____

Please list any Medications you presently take AND what condition you are taking them for:

____

Current supplements and **Why** you are taking them:

____

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)

____

YOUR LIFESTYLE

Height________ **Weight**_______Has your **weight** changed recently? Gained____ Lost___ No change ____

How many **hours of sleep**_________
Sleep position: Side Front Back
Quality of sleep: Poor Moderate Excellent
Do you drink **Alcohol**?_____drinks/day
Grind your teeth/clench? No Yes
How many **hours do you sit**? _____/day

Diet: Poor Moderate Excellent
Would you like advice? No Yes
Do you **Smoke**: No Yes ______cigs/day
Exercise: No Yes, ________/week

Gym/Cardio	Weights	Core	
Yoga	Pilates	Bootcamp	Crossfit
Swimming	Biking	Running	Other

For Women: Are you pregnant? ☐Yes ☐No Date of Last Period___________

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TREATMENT HISTORY:

	Name/Location	Date of last visit	Years of Care or # of treatments	Result of Treatment	Comments
Massage Therapy				Excellent Good Fair Poor	
Chiropractor				Excellent Good Fair Poor	
Physiotherapy				Excellent Good Fair Poor	
Naturopath				Excellent Good Fair Poor	
Acupuncture				Excellent Good Fair Poor	
Other (specify)				Excellent Good Fair Poor	

Other therapy / treatment: (past or present, does not have to be related to this visit)

Your **Medical Practitioner's** Name:____ Phone:_____________________
Date last seen ______________ Reason for visit __________ Recent medical testing: Xrays___ Blood test ____ Other____
Permission to contact your medical doctor (Signature) ____

FAMILY HISTORY

Please state **who** has/had condition (eg. maternal grandma), **how old** they were when **diagnosed**, & **what type** (eg. Lung CA). Have they passed away?

Cancer (Type) __________________________________Diabetes____________________Stroke______________________

Heart disease _______________Kidney disease ____________________Mental illness_________Seizures_____________

Autoimmune disorder_________Other:____

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated Practitioners to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated Practitioners to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: **Date:**