Courtenay Family Chiropractic

Exceeding Above & Beyond

Your Health Expectations

Confidential Patient Health History

***Please fully complete **without skipping questions**, or ask for assistance.

Name:_____ Today's Date: _____

Address: _____
Residence and Mailing City Province Postal Code

Home Tel:( ) _____ Cell: ( )_____

Work Tel:( )_____ Birth date: (mm/dd/yy) _____

Email: _____ **BC Care Card #**: _____

(your Email will NEVER be used outside this office)

Occupation: _____ Employed by: _____

Marital Status: _____ Partner's Name: _____

Number of children: _____ Names/ages of children: _____

Have you had previous chiropractic care? ☐ Yes ☐ No Chiropractor's name: _____

Date of last adjustment:_____Medical Doctor's name _____

Are you currently pregnant? _____ If yes, your due date? ____

Who may we thank for referring you to our clinic? _____

Have you ever worn custom foot orthotics or inserts in your shoes? _____ Age of most recent pair? _____

Reason for consulting our office: _____

Other problems you are concerned with? _____

Is this a work (**WCB**) or motor vehicle accident (**ICBC**) related injury? ☐ YES ☐ NO

- Claim number? _____
- Date of injury? _____

ALL Car Accidents:

Date: _____ Injuries: _____

Date: _____ Injuries: _____

Do you have **extra (extended) health insurance** through your (or partner's) employment? ☐ YES ☐ NO

(ie. Pacific Blue Cross, Great West Life, Manulife)

Your Health Profile

Why This Form Is Important

As a full spectrum Chiropractic clinic, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us profiles of the specific stresses you have faced in your lifetime, allowing us to better assess your health challenges.

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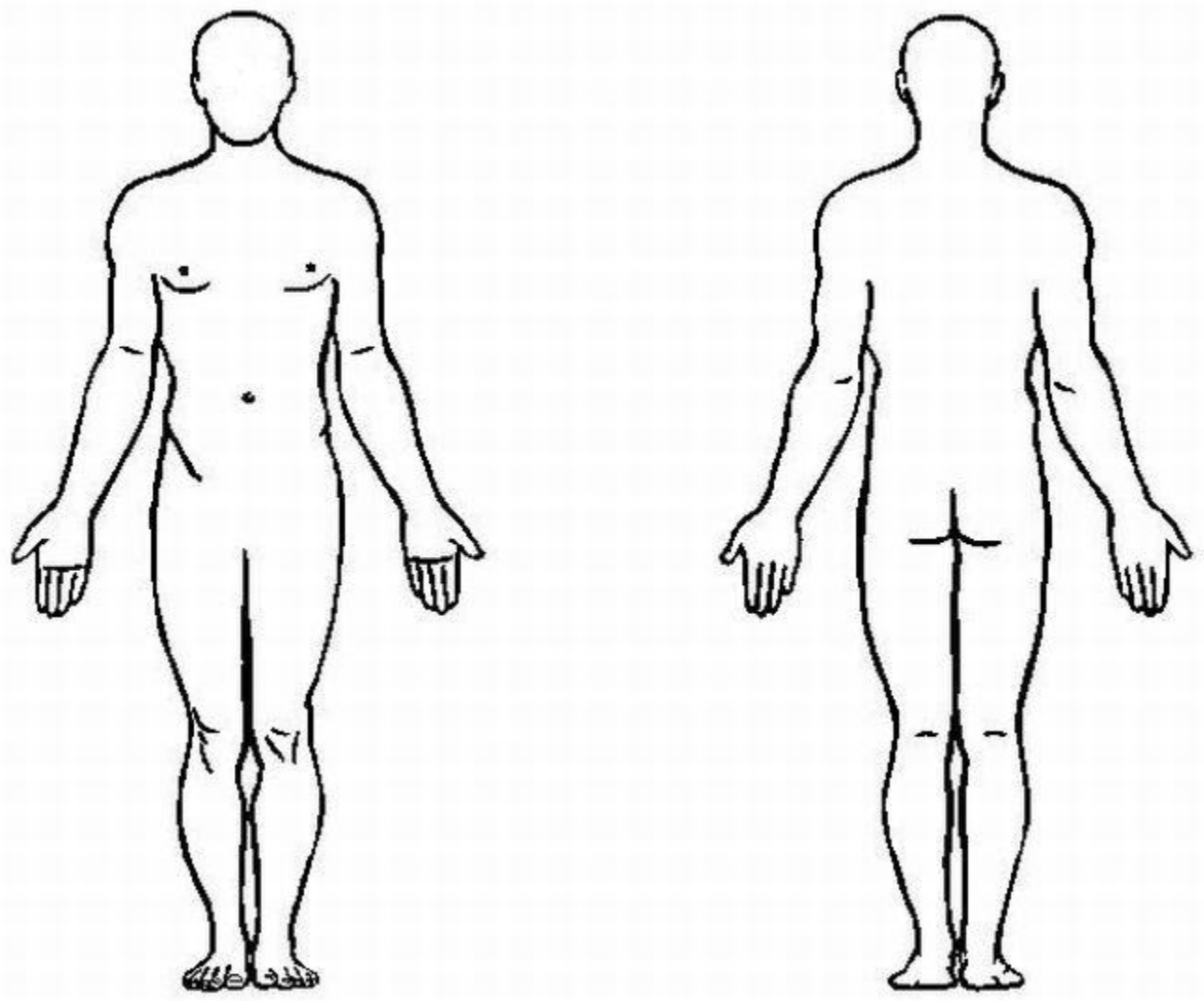
In the diagrams provided below, please mark the areas of your body which you feel best represent the pain(s)/discomfort(s) or sensation(s) you are experiencing**. Please include <u>all</u> areas**. Use the symbols provided below. Also, in order to complete the picture, please draw in your face.

SYMBOLS:

llll	numbness	••••	pins and needles
////	burning	= =	stabbing & sharp
xxx	dull & aching	+++	stiff & tight



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The Beginning Years (Under Age 18)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth.Please answer **all** of the following questions to the best of your ability.

	Yes	No	Unsure
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐

	Yes	No	Unsure
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas? (physical or emotional)	☐	☐	☐

	Yes	No	Unsure
Did you have any surgeries?	☐	☐	☐
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	Yes	No	Unsure
Were you vaccinated?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

Adult Years (Age 18 to present)

	Yes	No
Do/did you smoke?	☐	☐
Do/did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐

	Yes	No
Do/did you play any adult sports?	☐	☐
Do/did you participate in extreme sports?	☐	☐

On a scale of 1-10 describe your stress level:
(1 = none, 10 = extreme)
Occupational:_____ Personal:_____

Using **P**OOR, **G**OOD, or **EX**CELLENT, describe your: Diet_____ Exercise_____ Sleep_____ General Health_____

If you have no symptoms or complaints, and are here for **wellness** services, please check (√) here _____ and skip to "**Seemingly Unrelated Symptoms**".

Those who have **symptoms** or **complaints** need to briefly describe the chief area of complaint, the main effect it has had on your life, when you first noticed it, and how it originally occurred.

_____

_____

_____

If you are experiencing pain, is it (check all those that apply):

☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing ☐ Radiating

Since the problem started, is it: ☐ About the Same? ☐ Getting Better? ☐ Getting Worse?

What makes it worse? _____

How frequent is the complaint? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only

How long does it last? ☐ All day ☐ A Few Hours ☐ Minutes

Is there anything you can do to relieve the problem? ☐ Yes ☐ No If yes describe: _____

It interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

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0 1 2 3 4 5 6 7 8 9 10

Please mark an **X** on the line above to indicate your pain level

Seemingly Unrelated Symptoms can often manifest as other health concerns: Please check (√) all symptoms you have ever had, ***even if they do not seem related to your current problem.***

☐ Headaches	☐ Loss of Taste	☐ Weight Loss/Gain	☐ Neck Pain
☐ Dizziness	☐ Light Sensitivity	☐ Dental Problems	☐ Upper Back Pain
☐ Fainting	☐ Face Flushed	☐ Fevers	☐ Lower Back Pain
☐ Fatigue	☐ Cold Sweats	☐ Heart Palpitations	☐ Radiating Pain
☐ Irritability	☐ Bronchitis	☐ Chest Pressure	☐ Neck/Back Stiffness
☐ Depression	☐ Pneumonia	☐ Breast Pain	☐ Reduced Mobility
☐ Loss of Balance	☐ Difficulty Breathing	☐ Frequent Colds/Flus	☐ Numb in Arms/Hands
☐ Loss of Concentration	☐ Shortness of Breath	☐ Sinus Congestion	☐ Numb in Legs/Feet
☐ Loss of Memory	☐ Asthma	☐ Sore Throats	☐ Emotional Stress
☐ Ears Buzzing	☐ Urinary Problems	☐ Ear Pain / Infections	☐ Weakness
☐ Poor Coordination	☐ Constipation	☐ Allergies	☐ Muscle Cramps
☐ Vision Changes	☐ Diarrhea	☐ Upset Stomach	☐ Cold Hands/Feet
☐ Mood Swings	☐ Menstrual Pain	☐ Heartburn	☐ Sleeping Problems
☐ Loss of Smell	☐ Menstrual Irregularities	☐ Bloating/Gas	☐ Anxiety

☐ Other: _____

Please note any ***major illnesses*** you have had: ☐ Heart disease ☐ Cancer ☐ Diabetes Other: _____

Please list below any ***major accidents*** and **ALL *surgeries*** you have had:

Please list below **ALL *medications*** you are taking, either periodically or regularly:

Family Health History

The health history of family members often gives insight into your past, current, or future health. Please list below any health conditions or concerns you are aware of with your:

	Name(s):	Condition(s):
Grandparents:		
Parents:		
Siblings:		
Others:		

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Stress Test

When in your life did you experience **any** of the following stresses (circle): **C** (child), **T** (teenager), **A** (adult), **N** (not at all)

I. PHYSICAL STRESS:

					Explain
Birth Trauma	C	T	A	N	
Slips/Falls	C	T	A	N	
Sports Injuries	C	T	A	N	
Poor Posture	C	T	A	N	
Extensive Computer Work	C	T	A	N	
Carrying Heavy Objects	C	T	A	N	
Repetitive Lifting/Bending	C	T	A	N	
Continuous Sitting/Standing	C	T	A	N	
Bone Fracture/Surgery	C	T	A	N	
Driving For Many Hours	C	T	A	N	
Car Accidents (How many? ____)	C	T	A	N	
Physical Abuse	C	T	A	N	
Work Injuries (How many? ____)	C	T	A	N	
Sleeping on Stomach	C	T	A	N	

II. CHEMICAL STRESS:

					Explain
Smoker – Amount? _____	C	T	A	N	
Second-Hand Smoke	C	T	A	N	
Poor Diet	C	T	A	N	
Caffeine – Amount? _____	C	T	A	N	
Excessive Sugar	C	T	A	N	
Artificial Sweeteners (ie. diet pop)	C	T	A	N	
Prescription Drugs	C	T	A	N	
Over-The-Counter Drugs (Tylenol, Advil, etc.)	C	T	A	N	
Environmental Pollution (Air, Water, etc.)	C	T	A	N	

III. EMOTIONAL STRESS:

					Explain
Relationships	C	T	A	N	
Career	C	T	A	N	
Children	C	T	A	N	
Money	C	T	A	N	
Fast-Paced Life	C	T	A	N	
Internalized Feelings	C	T	A	N	
Perfectionist	C	T	A	N	
Procrastinator	C	T	A	N	
Sickness or Loss of a Loved One	C	T	A	N	
Quick Temper	C	T	A	N	
Verbal Abuse	C	T	A	N	

IV. WHICH DO YOU FEEL IS YOUR PRIMARY STRESS? ☐ PHYSICAL ☐ CHEMICAL ☐ EMOTIONAL?

Explain: _____

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Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this_____ day of_____, 20_____.

_____ _____
Patient Signature (Legal Guardian) **Witness of Signature**

Name:_____ **Name:_____**
(please print) **(please print)**

****

Dr. Ken Heinrich Dr. Marnie Grant

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