Performance
HEALTH GROUP
Correct • Prevent • Excel

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Initial Consultation

About the Patient

Name _____

Address _____

City _____ Province _____ Postal Code _____

Home Phone _____Cell Phone _____

E-mail _____

Age_____ Gender M F Birth date _____

Type of Work _____

Emergency Contact _____

Family Physician _____

Have you had chiropractic care and/or ART and/or PT before?

- ❒ Yes, when and by whom? _____
- ❒ No

Referred to this office by _____

Reason for the Visit

Describe the purpose of this visit _____

_____

_____

Is this a motor vehicle accident or work place injury related visit?

- ❒ ICBC Claim #_____
- ❒ Worksafe Claim #_____

How do you think this condition began? _____

_____

When did this condition begin? _____

_____

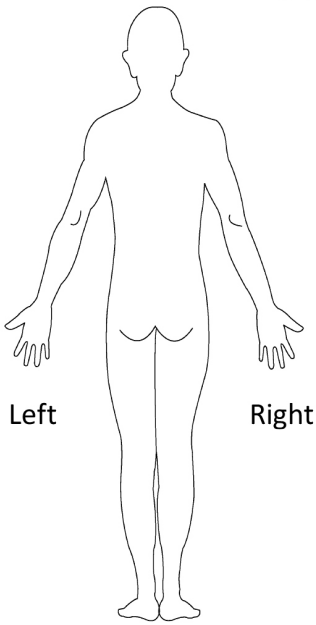
Do you have a previous history of this condition?

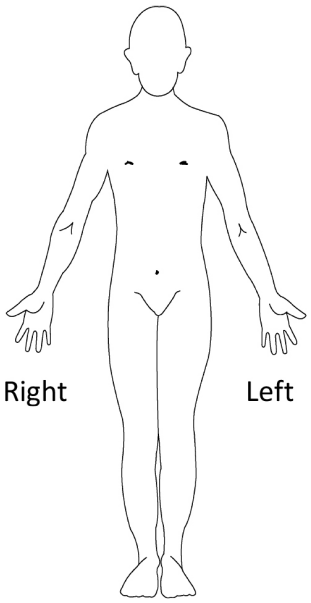
- ❒ Yes, how long ago?_____
- ❒ No

Show Area(s) of Pain or Unusual Feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness - - - - -
Pins & Needles 00000
Burning xxxxx
Aching *****
Stabbing / / / / /





On a scale of zero to 10, I rate my discomfort as follows:

Neck-Shoulder-Arm-Pain

(_____)
0 10
no pain severe pain

Mid Back Pain

(_____)
0 10
no pain severe pain

Low Back and Leg Pain

(_____)
0 10
no pain severe pain

HEALTH CONDITIONS

Please check each of the conditions that you have or had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- ❒ Low back pain
- ❒ Disc injury
- ❒ Pain in legs
- ❒ Tingling in legs
- ❒ Pinched nerves
- ❒ Neck Pain
- ❒ Grating in neck
- ❒ Pain in Arms
- ❒ Tingling in arms
- ❒ Tight shoulder muscles
- ❒ Shoulder blade pain
- ❒ Mid back pain
- ❒ Swollen joints
- ❒ Painful joints
- ❒ Swollen ankles
- ❒ Indigestion
- ❒ Constipation
- ❒ Diarrhea
- ❒ Twitching of face
- ❒ Lights bother eyes
- ❒ Hay fever
- ❒ Sinus trouble
- ❒ Tuberculosis
- ❒ Loss of memory
- ❒ Shortness of breath
- ❒ Depression
- ❒ Fatigue
- ❒ High Blood Pressure
- ❒ Ulcer or Stomach Problems
- ❒ Heart Attack
- ❒ Stroke
- ❒ Emphysema
- ❒ Seizure-Convulsions
- ❒ Arthritis-Rheumatism
- ❒ HIV Positive
- ❒ Mental Illness
- ❒ Asthma
- ❒ Thyroid Disease
- ❒ Diabetes
- ❒ Circulation Problems
- ❒ Kidney Disease
- ❒ Cancer
- ❒ Anemia
- ❒ Liver Problem
- ❒ Difficulty with urination

For women:

- ❒ Are you pregnant?
- ❒ Are you taking birth control?
- ❒ Menstrual cramps
- ❒ Menstrual irregularity

For men:

- ❒ Enlarged Prostate

PAST HEALTH HISTORY

Have you had any major falls, car accidents or injuries? No___ Yes___
If yes, Please explain (give month and year and areas injured)_____
_____
Have you ever had any surgery? No___ Yes___
If yes, Please explain (give month and year) _____
_____
Have you ever broken any bones? No___ Yes___ Any dislocations? No___ Yes___
Have you been hospitalized recently? No___ Yes___ If yes, please describe_____
Have you had any special exams performed recently (x-ray, urine, blood, CT, MRI, US etc.) No___ Yes___
If yes, please describe what procedure and reason_____
Are you currently under the care of a doctor for any other reason? No___ Yes___
If yes, Please explain _____
What prescription medication are you taking if any?

- ❒ High blood pressure medication
- ❒ Blood thinners
- ❒ Diabetes medication
- ❒ Herb, vitamins, or over the counter products_____
- ❒ Other_____

SOCIAL HEALTH HISTORY

	Yes	No	
Do you smoke?	☐	☐	How many packs/day?_____
Do you drink alcohol?	☐	☐	How much?_____

Please note: Your appointment time has been reserved for you. In courtesy of your Doctor, therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged.

Signature: _____ Date: _____