PATIENT INFORMATION FORM

DATE: ______________________

NAME: ______________________

For Office Use Only	
❑ G1 (user's fee)	❑ Exempt
❑ DVA	❑ RCMP

B.C. PERSONAL HEALTH NUMBER: ______________________

IF YOU HAVE EXTENDED HEALTH BENEFITS - YOU MAY BE ELIGIBLE FOR REIMBURSEMENT

ADDRESS: ______________________

CITY: __________ PROV: __________ POSTAL CODE: __________

SEX: ❑ M ❑ F DATE OF BIRTH: _____ / _____ / _____ AGE: ______
YEAR MONTH DAY

HOME PHONE: __________ BUSINESS PHONE: __________

OCCUPATION: __________ EMPLOYER: __________

Email address: ______________________

IS THIS A WORK RELATED INJURY? ❑ NO ❑ YES CLAIM #: __________

MOTOR VEHICLE ACCIDENT INJURY? ❑ NO ❑ YES CLAIM #: __________

DATE OF ACCIDENT: __________

PREVIOUS CHIROPRACTIC CARE? ❑ YES ❑ NO

BY WHOM: __________ WHEN: __________

ARE YOU CURRENTLY SEEING ANOTHER PRACTITIONER? ❑ NO ❑ YES

❑ MASSAGE THERAPIST ❑ PHYSIOTHERAPIST ❑ NAME: __________

WHO REFERRED YOU TO THIS OFFICE? ______________________

WHO IS YOUR MEDICAL DOCTOR? ______________________

DO YOU HAVE REASON TO THINK YOU ARE PREGNANT? ❑ NO ❑ YES

HAVE YOU EVER:	YES	NO	*If yes, briefly explain:*
Had a motor vehicle accident?	❑	❑	
Been struck unconscious?	❑	❑	
Had a broken bone?	❑	❑	
Used a cane, crutch or other support?	❑	❑	
Been hospitalized / had surgeries?	❑	❑	
Been hospitalized for other than surgery?	❑	❑	
Had any falls or other injuries?	❑	❑	

DO YOU:	YES	NO	
Take minerals, herbs, or vitamins?	❑	❑	
Have any allergies?	❑	❑	

WHEN DID YOU LAST HAVE:	Never	0-6 mo	6-18 mo	Longer	
Spinal x-ray	❑	❑	❑	❑	
Spinal examination	❑	❑	❑	❑	
Physical examination	❑	❑	❑	❑	

ARE YOU CURRENTLY TAKING ANY MEDICATIONS:

❑ pain killers ❑ muscle relaxants ❑ anti-inflammatories ❑ cold medications

❑ other ______________________

PLEASE LIST ANY SIGNIFICANT ILLNESS OR MEDICAL CONDITION, PAST OR PRESENT:

____

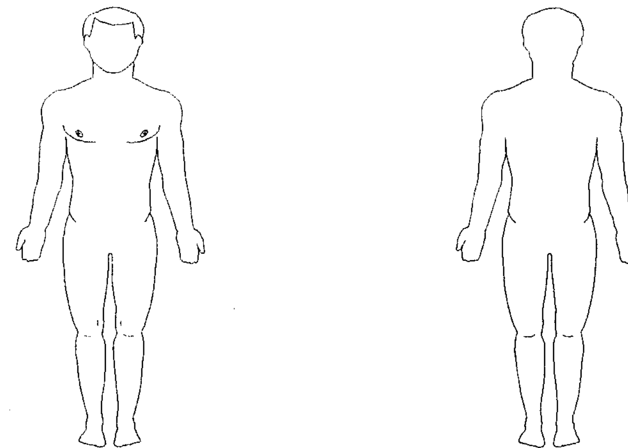
BRIEFLY DESCRIBE YOUR PRESENT COMPLAINT: ______________________

DO YOU HAVE DIFFICULTY WITH THE FOLLOWING? IF YES, MARK "X".

- ❑ HEADACHES
- ❑ VISION BLURRY/CHANGE
- ❑ LOSS OF SMELL/TASTE
- ❑ RINGING IN EARS
- ❑ JAW PAIN
- ❑ TIGHTNESS OF THROAT
- ❑ DIZZINESS / FAINTING
- ❑ LOSS OF BALANCE
- ❑ NECK PAIN
- ❑ TINGLING OR NUMBNESS IN ARMS OR HANDS
- ❑ SPINAL INJURY
- ❑ SHOULDER, ARM OR HAND PAIN
- ❑ CHEST PAINS
- ❑ SHORTNESS OF BREATH
- ❑ STROKE
- ❑ MID-BACK PAIN
- ❑ STOMACH COMPLAINTS
- ❑ ABDOMINAL PAIN
- ❑ CONSTIPATION/DIARRHEA
- ❑ MENSTRUAL CRAMPS, PAIN OR IRREGULARITY
- ❑ HEAD INJURY
- ❑ LOW BACK PAIN
- ❑ HIP, LEG or FOOT PAIN
- ❑ TINGLING / NUMBNESS IN LEGS or FEET
- ❑ IRRITABILITY
- ❑ SLEEPING PROBLEMS
- ❑ MEMORY LOSS
- ❑ STIFF/PAINFUL JOINTS
- ❑ CANCER
- ❑ DIABETES
- ❑ EPILEPSY
- ❑ BLOOD PRESSURE HIGH OR LOW

❑ OTHERS (PLEASE EXPLAIN): ______________________

PLEASE MARK ON THE DIAGRAM THE AREA(S) OF YOUR DISCOMFORT



PLEASE RATE THE LEVEL OF PAIN YOU ARE FEELING TODAY (PLEASE MARK THE LINE).