

CONFIDENTIAL CASE HISTORY

Name: _____ Care Card Number: _____
 Address: _____ City: _____ Provenance _____ Postal Code: _____
 E-mail Address: _____
 Phone: (H) _____ (W) _____ (C) _____

Occupation: _____ Full or Part Time: _____ Date of Birth: _____
 Physician: _____ Date of last physical with physician: _____

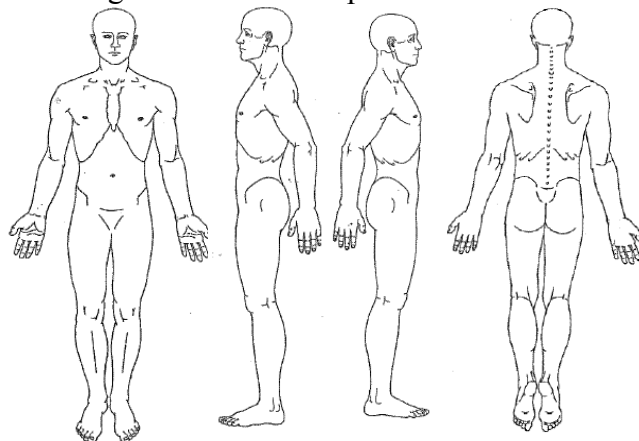
Motor Vehicle Accident (MVA), ICBC, or WCB related? If yes, please inform the staff and note the date: _____

How did you learn about our clinic and the services we provide? _____

Marital Status: _____ Children (Y/N), if applicable, please include age: _____

Reason for treatment/Pain location (condition/symptoms): _____

Please circle/mark the diagram below in the places that most accurately represent any pain you are experiencing:



Prior Injuries (Please circle): Fall/Fracture/Sprain/Dislocation/Head Injury/Spinal Injury/Disc Injury
 **Please describe the previous injury's date, treatment and recovery status: _____

Please not the following as it may apply to you: **P=past / C=current / F=immediate family history**

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Kidney Condition | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Headache/Migraine | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Contagious Condition | <input type="checkbox"/> Respiratory Condition | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Recent Weight loss/gain | <input type="checkbox"/> Unexplained Fatigue | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Epilepsy | _____ |

Are you currently being monitored by a health professional for a pre-existing condition?

Y/N, if yes, please

describe: _____

Medications (please list): _____

Supplement intake: _____

General Health: _____

Average Coffee/Tea consumption: _____ Average Alcohol consumption: _____

Do you smoke currently? Y/N, if yes, how much? _____ In the past? Y/N _____

Activity Level: high/moderate/low

Current Activities and frequency: _____

Goal with treatment: _____

Have you received previous chiropractic care? Y/N _____

If yes, when? _____ Was it a positive experience? _____

Reason for Consulting Bayside Chiropractic

I have a specific problem and only require help with this problem

After my problem has been resolved, I am interested in strategies to ensure the problem does not return

Spinal checkup and to improve my general health and performance

Your appointment time is reserved for you. Please note that to cancel or change your appointment time, a minimum of 24 hours is required to avoid a cancellation fee. If 24 hours notice is not given, a late/cancellation fee of \$35.00 will be charged. Thank you for your cooperation.

Please initial _____

Signature X _____

Date _____

