Required for Your Case History File: All Information Is Confidential

Full Legal Name_____ Name you prefer_____

BC Care Card Number_____ Date of Birth_____ Age_____

Mailing Address_____

City_____ Prov_____

Telephone (Home) _____ Telephone (Work) _____

Email _____ Cell _____

Occupation_____ Employer_____

Check one: Married☐ Single☐ Widowed☐ Divorced☐ Separated☐ Number of Children_____

Emergency Contact _____Telephone_____

Referred by_____

Past chiropractic care? Yes☐ No☐ If yes, who? _____

Who is your primary care physician? _____

Last Physical Examination_____ Have you been treated for any health condition by a physician in the last year? Yes☐ No☐ If yes, explain_____

What medications/vitamins/herbs are you taking?_____

Are you allergic to any medications? Yes☐ No☐ If yes, list _____

Previous serious illness/ hospitalization: (Please date & describe) _____

_____

Have ever had: Surgery - Yes☐ No☐ Fractures - Yes☐ No☐ Car Accidents - Yes☐ No☐
Falls - Yes☐ No☐ On-Job Injury - Yes☐ No☐ Describe: _____

_____

Family history of: Heart disease - Yes☐ No☐ Cancer - Yes☐ No☐ Diabetes - Yes☐ No☐
Arthritis - Yes☐ No☐ Back problems - Yes☐ No☐ Other_____

If female, are you possibly pregnant? Yes☐ No☐ Date of last menstrual period _____

Major Symptom/Problem for this visit _____

_____

Date symptoms first began _____

How did your symptoms first begin? _____

Other Symptoms _____

Pain is: Constant☐ Intermittent☐ Is your condition getting? Worse☐ Better☐ Same☐

What activities aggravate your condition?_____

What activities lessen your symptoms? _____

Is condition worse during certain times of the day?_____

Is this condition interfering with work? Yes☐ No☐ sleep? Yes☐ No☐ routine? Yes☐ No☐

Other doctors seen for this condition _____

List home remedies tried _____

Have you ever had or do now have any of the following?

Use the letter C if you have a current condition, or the letter P if you have previously had the condition.

C = Currently P = Previously

___Headaches	___Hearing Loss	___Nausea or Vomiting
___Arm/Shoulder Pain	___Buzzing or Ringing in Ears	___Gout
___Arm or Shoulder Weakness	___Depression/Anxiety	___Pain or Trouble Breathing
___Neck Pain/Stiffness	___Nervousness	___Tuberculosis
___Mid Back Pain/Stiffness	___Fatigue or Weakness	___Pneumonia
___Low Back Pain/Stiffness	___Loss of Energy	___Cold/Flu/Cough
___Pins & Needles in Arms	___Sleeping Problems	___ Sore Throat
___Pins & Needles in Legs	___Seizures	___Difficulty Swallowing
___Numbness in Fingers/Toes	___Loss of Memory	___Skin Disease/Ulcers
___Leg or Foot Pain	___Loss of Balance	___Rashes
___Osteoporosis	___Parkinson's	___Hives
___Asthma or Emphysema	___Fainting or Convulsions	___Gallbladder
___Sinus Trouble or Allergies	___Heart Trouble or Stroke	___Liver
___Bleeding Gums	___Chest Pain	___Hepatitis
___Easy Bleeding/Bruising	___High Blood Pressure	___Ulcers
___Blood in Urine or Stool	___Dizziness	___Thyroid Problems
___Burning/Frequent Urination	___Poor Circulation	___Diabetes
___Kidney Disease/Stone	___Leg Cramps or Swelling	___Immuno-suppression
___Glaucoma	___Rheumatic Fever	___Abnormal Menstrual
___Blurred Vision	___Anemia	___Breast Problems
___Loss of Taste	___Digestive or Eating Problems	___Prostate Problems
___Loss of Smell	___Constipation or Diarrhea	___Sexual Dysfunction

Check if you have had any of the following symptoms in the last 30 days:

Pain worse at night☐ Constant pain unrelated to motion☐ Unexplained weight loss☐

Loss of bowel or bladder control☐ Bacterial infection☐ Surgery☐ Fever or chills☐

Check if you have ever had any of the following:

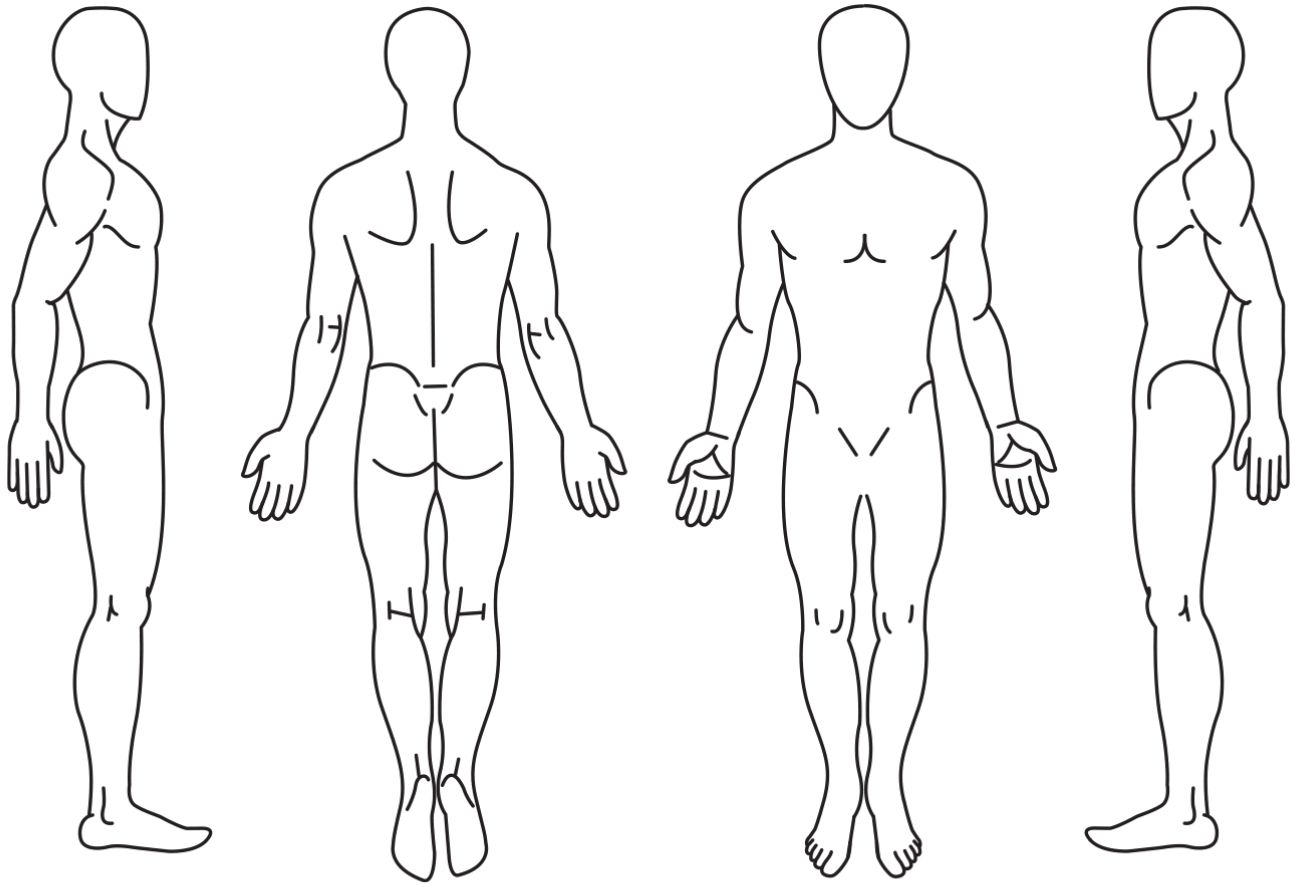
History of Cancer☐ History of HIV☐ Use of Steroids☐ Use of IV Drugs☐ Blood Transfusions☐

NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered. I understand that I am personally responsible for any remaining balance this office does not collect from insurance proceeds. I give permission to the clinic to perform necessary tests and treatments.

Signature _____Date _____ form 105 a

Where is your pain now? Mark the areas where you feel sensations using the appropriate symbols.
Please mark an X on the area where the pain is now worst.

Aching	Numbness	Pins and Needles	Burning	Sharp/Stabbing	Stiff/Tight
yyyyyy	= = = =	ooooo	zzzzz	/////	*****



How bad is your pain? On the scale below circle your pain.

		0	1	2	3	4	5	6	7	8	9	10	
Right now	No Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Worst Possible Pain
On Average.....	No Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Worst Possible Pain
At its very worst ...	No Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Worst Possible Pain

Overall, is your pain generally: improving ☐ same ☐ worsening ☐

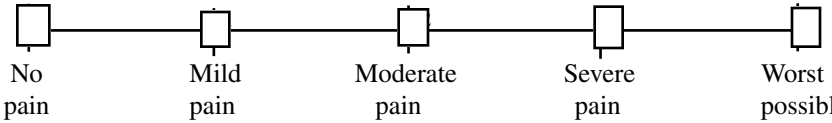
Name: _____ Date: _____

Functional Rating Index

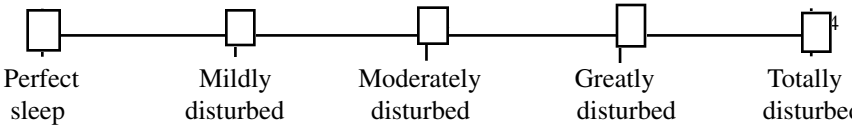
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

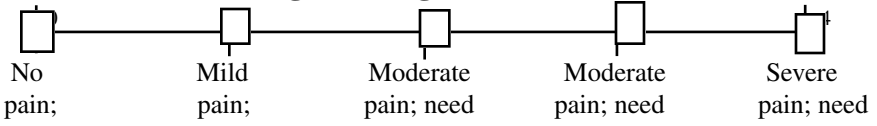
1. Pain Intensity



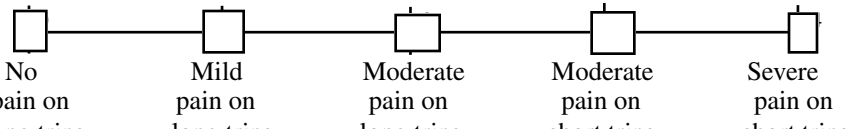
2. Sleeping



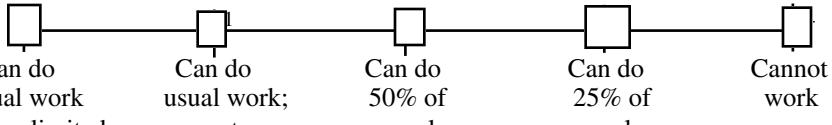
3. Personal Care (washing, dressing, etc.)



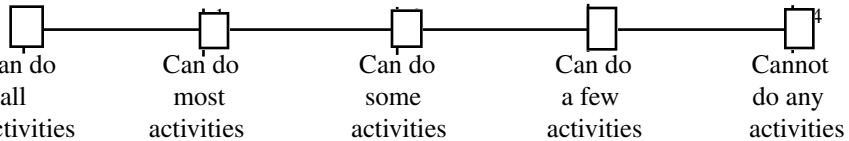
4. Travel (driving, etc.)



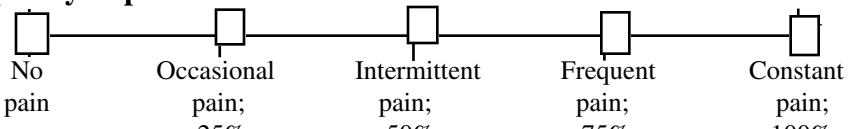
5. Work



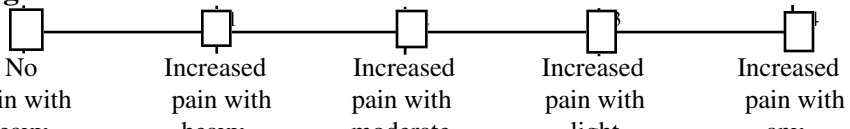
6. Recreation



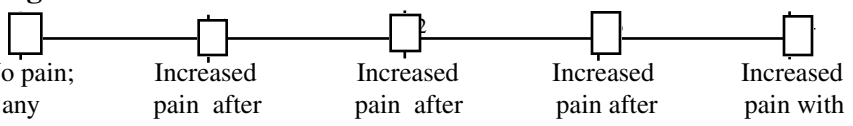
7. Frequency of pain



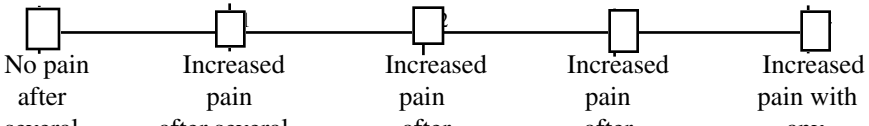
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

1st follow-up: E-B info ❒

_____
Signature

_____
Date