ABBOTSFORD CHIROPRACTIC CENTRE

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Safe, Smart, Effective Health Care

Confidential Patient History Form

Please Print Clearly

Name ____ Carecard #_________________________
Address ____ City__________________________
Postal Code ________________________ Occupation ___________________________________
Preferred Phone Number(s):______________________ / _________________________________
Birth Date (m) _________ (d) _______ (y) ______ Referring Doctor ________________________
How did you hear about our clinic? ____

Medical History
List any prescription medications you are presently taking________________________________
____
____
List any NON-prescription medications you are presently taking___________________________
____
List any surgeries, injuries, or accidents you have had____________________________________
____
Known allergies____

Current Condition
Please describe your current condition & symptoms:
____
____
____
How long have you had this condition?
____
____
How did it start?
____
____
What aggravates it?
____
What relieves it?
____
Have you had this condition in the past? ☐ Yes ☐ No

Is this an ICBC or WCB case? ☐ Yes ☐ No

Are you also seeing?
☐ Chiropractor ☐ Physiotherapy ☐ Naturopath ☐ Acupuncture ☐ Other _______________

Are you: ☐ Right Handed ☐ Left Handed

Turn Over ☞

List any Activities, Sports, Hobbies (i.e. Jogging, Hockey, Crafts, Computer, etc.)

____

____

Please CIRCLE the answers closest to how
you PRESENTLY feel (1 = poor/low, 5 = excellent/high)

Quality of Sleep	1	2	3	4	5		Smoker	□ Yes □No □Occasional
Energy Level	1	2	3	4	5		Alcohol	□Yes □No □Occasional
Eating Habits	1	2	3	4	5		Water	(approx. cups)
Stress Level	1	2	3	4	5		Hours of Sleep/Night	(approx.)
Exercise Habits	1	2	3	4	5			

Please place a checkmark beside ANY of the following conditions that apply to you:

Heart Condition	Osteo/Rheumatoid Arthritis	Contagious Condition
High/Low Blood Pressure	Fibromyalgia	Hepatitis
Stroke or Aneurysm		HIV/Aids
Pace Maker	Dizziness/Fainting	
		Skin Condition
Circulatory condition	Headaches/Migraines	
Varicose Veins		Cancer (past/present)
Bruise Easily	Skeletal Condition	Tumours/Cysts
	Osteoporosis	
Kidney/Urinary Condition		Fracture/Dislocation
Diabetes	Neurological Condition	Pins or Plates
	Spinal Injury	
Respiratory Condition	Head Injury	Menstrual Problems
	Epilepsy/Seizures	Pregnancy
Digestive Disorder	Numbness/Tingling	Other: _________________

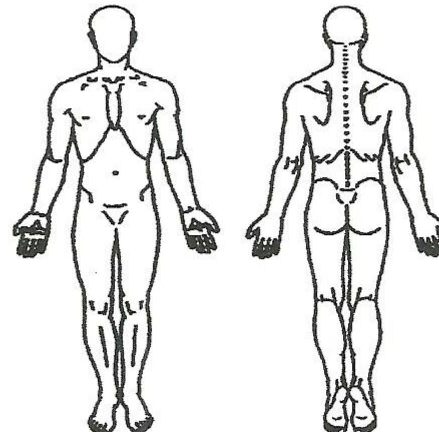
Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide us with **24 hours** notice of cancellation, or a cancellation fee will be charged. Payment for all treatments, whether private or insured, is ultimately the responsibility of the patient. I agree to pay in full the amount due at the end of each session. Cash, Cheque, Debit, Visa and Mastercard are all accepted.

I authorize the collection, use and disclosure of my personal information as defined in the *Personal Information and Privacy Act (PIPA)* required for treatment and/or any related administrative purposes. I understand that all of my personal information is confidential, and must be treated in accordance with PIPA. By my signature I confirm that I have read the forgoing and agree to the terms set out above.

Signature: _______________________________

Date: _______________________________

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching O O
Stabbing X X X
Shooting → →
Burning # # #
Numbness or Tingling ≈ ≈