



Name _____ BC Medical (CareCard)# _____

Date of Birth (M/D/Y) _____ Age _____ Gender M or F Marital Status _____ # Children _____

Address _____ City _____ Province _____ Postal Code _____

Home Phone # _____ Cell Phone _____ Email _____

Please star (*) beside the best number to call you at during daytime hours (8:30am-6pm)

Would you like email appointment reminders? Yes No

Your Occupation _____ Company _____ City _____ Work # _____

Spouse/Guardian's Name _____ Occupation _____ Phone _____

How did you hear about us? Yellow Pages Sign Website Friend: _____ Other: _____

Do you have extended health benefits? Yes No Company _____

Do you currently wear orthotics? Yes No Are you interested in gait analysis? Yes No

GOALS FOR CARE: Check all that apply

- RELIEF I want to feel better for the least amount of my time and money.
- CORRECTION I want to stabilize and retrain the muscles and ligaments of my spine and skeletal system.
- MAINTENANCE I want to preserve the progress I've made
- PREVENTION I want to avoid losing my health
- WELLNESS I want to be all that I can be, high quality performance, sleep, energy, immune system, maximum brain power and more.

MAJOR HEALTH CONCERN: _____

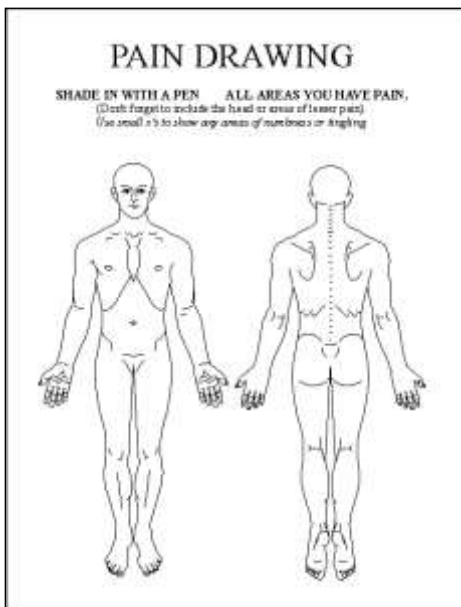
When did it start? _____

What would you like to do but can't because of this problem? _____

List other professionals seen for this: _____

Is this **work related**? NO YES If yes, have you Reported to employer? NO YES

Related to **automobile accident**? NO YES **ICBC claim #** _____



What makes it **better** (positions/activities/movements)? _____

What makes it **worse**(positions/activities/movements)? _____

What % of each day does it **bother you**? (Circle one)

0% 25%(Intermittent) 50%(Occasional) 75%(Frequent) 100%(Constant)

Does this **affect you** at:

Work Play/Activities/Exercise Sleep Romance/Love life

Have you had this condition **before**? YES NO **When?**: _____

Is your condition: getting **better**? getting **worse**? staying the **same**?

Please mark on the line, the pain level that most accurately represents your pain for **each** body area:

Average pain: 0 1 2 3 4 5 6 7 8 9 10 | Unbearable



PERSONAL HEALTH HISTORY - The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

GENERAL CURRENT CONDITIONS

- Recent accident such as a fall, whiplash, or blow to the head
- Spinal/back/neck problems
- Muscle spasms
- Restricted movement
- Numbness or tingling of hands or feet or radiating pain
- Headaches or Migraines
- Sinus problems
- Nausea
- Depression
- Anxiety or difficulty with stress
- Dizziness or vertigo
- Vision problem
- Hearing problem
- Sleeping trouble
- Asthma or breathing problem
- Digestive trouble
- Heartburn/Acid Reflux
- Menstrual problems
- Jaw or mouth problem
- Arm, shoulder, elbow or hand problem
- Leg, hip, knee or foot problem

DIAGNOSED CONDITIONS

- Born with bone or joint disorder
- Degenerative arthritis
- Rheumatoid arthritis
- Compression fracture
- Heart attack or heart disorder
- History of stroke or aneurysm
- Cancer
- Diabetes
- Gout
- Lupus
- Ankylosing spondylitis
- Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
- 3 or more months of steroid medications or intravenous drugs (past or present)
- Tuberculosis
- Hepatitis B or HIV infection
- Multiple sclerosis
- Thyroid or hormone disorder
- High blood pressure
- Convulsions/epilepsy
- OTHER:

SPECIFIC PAIN IN THE BODY

- Difficulty swallowing because of neck pain
- Pain or electric shocks in arms or legs when moving neck
- Leg pain worse with exercise
- Numbness of inner thighs
- Back pain with urinary problems
- Severe pain that interrupts sleep
- Constant pain that doesn't improve by changing positions or by lying down

SPECIFIC CURRENT CONDITIONS

- Poor balance
- Loss of bowel or bladder control
- Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- Memory loss after injury
- Recent, unexplained weight loss
- Recent progressive muscle weakness or shaking
- Recent or current fever over 102°F

Describe any **surgeries** / hospitalizations / motor vehicle accidents / sporting accidents / personal or work accidents / fractures / dislocations / & / or illnesses you've had and the **dates**: _____

Current Medications & Drugs: Please circle the ones that apply

Pain Relievers / Appetite Suppressants / Thyroid / Birth control / Blood pressure
Laxatives / Cortisone / Sleeping Pills / Antibiotics / Tranquilizers / Antacid
Cholesterol / Recreational: _____ / Anti Inflammatory / Muscle relaxants / Anti-anxiety

Rx: _____ Dosage: _____ Diagnosis: _____
Rx: _____ Dosage: _____ Diagnosis: _____
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List Current supplements: _____
Why are you taking them: _____
Over the counter _____ How often? _____

YOUR LIFESTYLE:

Height: _____ **Weight:** _____ Has your **weight** changed recently? Gained: ___ lbs. Lost: ___ lbs. OR No change

How many **hours of sleep:** _____

Sleep position: Side Front Back

Quality of sleep: Poor Moderate Excellent

Do you drink **Alcohol?** _____ drinks/day

Grind your teeth/clench? No Yes

How many **hours do you sit?** _____/day

Drink **coffee/tea/energy** drink? ___ cups/day

Do you **Smoke:** No Yes _____cigs/day

Exercise: No Yes, _____/week

Cardio Weights Core Yoga Pilate

For Women: Are you pregnant? Yes No Date of Last Period _____



FAMILY HISTORY Circle – Please state **who** has/had condition(eg. maternal grandma), **how old** they were when **diagnosed**, & **what type** (eg. Lung CA)

Spine problems / Autoimmune disorders / Arthritis Cancer (Type; _____) Diabetes / Heart disease / Stroke
Kidney disease / Mental illness / Seizures
Other: _____ Please state who has/had the condition: _____

Your **Medical Practitioner's** Name: _____ Phone: _____
Date last seen: _____ Reason for visit: _____ Recent medical testing (circle): Xrays Blood test
Other: _____
Permission to contact your medical doctor (Signature) _____

Have you been under Chiropractic care before (circle)? YES NO Results: Excellent Good Fair Poor
Chiropractor: _____ Years of care: ____ Last date seen: _____ Condition(s): _____

Office Fees

(We accept Cash, Personal Cheques, Debit, & Credit Card)

Chiropractic Treatments

- Initial Visit (30-45min) _____ \$ 60
 - Prepay 3 Treatments (including initial visit) _____ \$ 135
- Chiropractic Treatment (15min) _____ \$ 45
 - Prepay 3 Treatments (not including initial visit) _____ \$ 120

Student/Senior Rates

- Initial Visit (30-45min) _____ \$ 50
- Chiropractic Treatment (15min) _____ \$ 35

Kinesio Tape Application

- Up to 3ft of tape _____ \$ 5
- Over 3ft of tape _____ \$ 10

I understand that all services are to be paid in full at the time of service, unless other arrangements have made and agreed upon in writing. Please note that we require a minimum of 24 hours notice for any cancellations or changes or you may incur a penalty. **A fee will be charged to your account for all missed appointments.**

Signature: _____ Date: _____ Guardian Signature: _____



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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal &/extremity adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Patient Signature (Legal Guardian)

Witness of Signature

Name: _____

Name: _____



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