PATIENT INTRODUCTION FORM

LAST name:_____ Marital Status S M W D
First Initial

Address: _____ Spouse's name: _____

City:_____ Postal Code: _____ Number of children: _____

Telephone: H_____ W_____ C _____ Email _____

Sex: Male __ Female__ Date of Birth: M _____ D _____ Y_____ Age: _____

Family Physician: _____ Physician telephone number: _____

Occupation: _____ Referred by: _____

B.C. CARECARD #: _____ Any private Insurance: Y☐ N☐

Do you have reason to believe that you may be pregnant? No☐ Yes☐ Due date: _____

Is this a claim from: ICBC _____ WCB_____ Claim #: _____ Date of Accident _____

End date of claim: _____ Adjuster's name: _____ Telephone #: _____

REASON FOR VISIT: _____

_____

If you are experiencing pain, is it: Shooting Sharp Stabbing Throbbing Achy Burning Dull (*Please circle*)

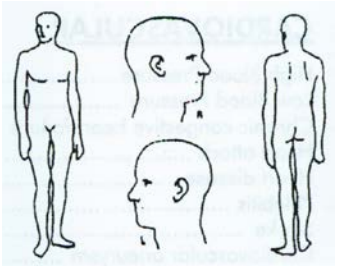
ARE YOU EXPERIENCING NUMBNESS OR TINGLING? Yes☐ No☐

How would you classify your pain level? Slight Moderate Severe (*Please circle*)

When did it start: _____

What relieves the condition: _____

What aggravates the condition: _____



Is the condition getting worse? Yes No Constant Comes and goes (*Please circle*) mark area

Have you seen a: Chiropractor Physiotherapist Massage therapist Acupuncturist Physician Other (*Please circle*)

For what condition and when:_____

Have you had any surgery? Yes ☐ No ☐ For what part and when? _____

Are you presently taking medication? Yes ☐ No ☐ If yes, please give name and what it's for: _____

In consideration of your practitioner and fellow patients, ***24 hour notice of change of appointment or cancellation*** **must be given or a fee will be charged. Patient is responsible for payment of services if medical insurance is not valid. _____ Initial please.**

Signature: _____ Date: _____

Please indicate conditions presently causing problems as well as conditions which were a problem in the past.

BABIES & CHILDREN	Present	Past
Birth trauma	☐	☐
Feeding problems	☐	☐
Colic	☐	☐
Recurrent ear infections	☐	☐
Developmental delays	☐	☐
Behavioural	☐	☐
Hyperactivity / ADD/ ADHD	☐	☐
Learning disabilities	☐	☐
Eye motor problems	☐	☐
PDD/autism	☐	☐

RESPIRATORY	Present	Past
Chronic Conditions	☐	☐
Shortness of Breath	☐	☐
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Allergies	☐	☐

CARDIOVASCULAR	Present	Past
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Chronic congestive heart failure	☐	☐
Heart attack	☐	☐
Heart disease	☐	☐
Phlebitis	☐	☐
Stroke	☐	☐
Cardiovascular aneurysm	☐	☐
Pacemaker / other device	☐	☐
Coldness in extremities	☐	☐
Varicose Veins	☐	☐
Arteriosclerosis	☐	☐
Poor Circulation	☐	☐

GASTROINTESTINAL	Present	Past
Heartburn	☐	☐
Pain or discomfort before eating	☐	☐
Pain or discomfort after eating	☐	☐
Nausea	☐	☐
Gas	☐	☐
Constipation	☐	☐
Hemorrhoids	☐	☐
Diarrhea	☐	☐
Ulcer	☐	☐
Digestive Problems	☐	☐
Eating Disorder (anorexia/bulimia)	☐	☐

HEAD/NECK/BACK	Present	Past
Headaches	☐	☐
Migraines	☐	☐
Dental Surgery	☐	☐
Orthodontics	☐	☐
Jaw Problems		
pain/clicking/locking	☐	☐
Whiplash	☐	☐
Vision Problems	☐	☐
Contact Lenses	☐	☐
Ear Problems	☐	☐
Fainting	☐	☐
Dizziness	☐	☐
Ringing in ears	☐	☐
Sinus Problems	☐	☐
Facial Pain	☐	☐
Head Injury	☐	☐
Spinal Injury	☐	☐
Other neurological conditions	☐	☐
List_____	☐	☐
_____	☐	☐

OTHER CONDITIONS		
HIV/AIDS	☐	☐
TB	☐	☐
Skin Conditions	☐	☐
Hepatitis	☐	☐
Diabetes		
Onset Date: _____		
Epilepsy	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Susceptible to colds / infections	☐	☐
High Stress Levels	☐	☐
Insomnia / Sleep Disorders	☐	☐
Depression	☐	☐
Fatigue	☐	☐
Nervousness	☐	☐
Numbness and/or tingling	☐	☐
Osteoporosis	☐	☐
Infectious conditions	☐	☐
Malaria	☐	☐
STD's	☐	☐
Tumors / Cysts	☐	☐
Swollen Ankles	☐	☐
Bruise easily	☐	☐
Joint Pain	☐	☐
Joint replacement	☐	☐
Fractures	☐	☐
Fibromyalgia	☐	☐
IUD	☐	☐
Gynecological concerns (specify)	☐	☐
Other:_____	☐	☐
_____	☐	☐