Cascadia Chiropractic Centre

New Patient Information & Clinical Record

Name:		Date:
Date of Birth:	Your age:	Care Card #:
Address:		City/Prov:
Postal Code:	Phone:	Cell:
Work Phone:	E-mail Address:	
Marital Status:	Spouse's Name:	Number of Children:
Occupation:	Employer:	Student: Y N
Are You Pregnant?	If yes, due date:	
Are you claiming under WCB?	If yes, Claim #:	
Are you claiming under ICBC?	If yes, Claim #:	
Are you covered by DVA/RCMP?	If yes, K/R #:	
How would you like to be reminded of your appointments? (Circle One)		Text Email Phone
If text, cell phone company (Bell, Telus, Rogers, Virgin, Fido etc.)?		
Do you have extended healthcare benefits?		
How did you hear about our office?		

A. PRESENTING COMPLAINT

In your own words describe your main complaint or reason for your visit?

____

____

____

When did it start? List date of onset or approximately how long ago it started: ______________________

How did it start, did you do anything in particular to start this complaint?

____

Have you had a similar complaint in the past? Yes / No Details: ________________________________

Have you seen another provider for this? _________ If yes, how long ago? _________

State the type of treatment (Chiro/Physio/MD/Specialist): ________________________________

Who provided it? ________________________ What were the results? ______________________

My complaint is progressively:
☐ Getting better ☐ Staying the same ☐ Getting worse

This complaint is:
☐ Constant ☐ Comes and goes

The symptoms are worse in the:
☐ Morning ☐ Daytime ☐ Evening

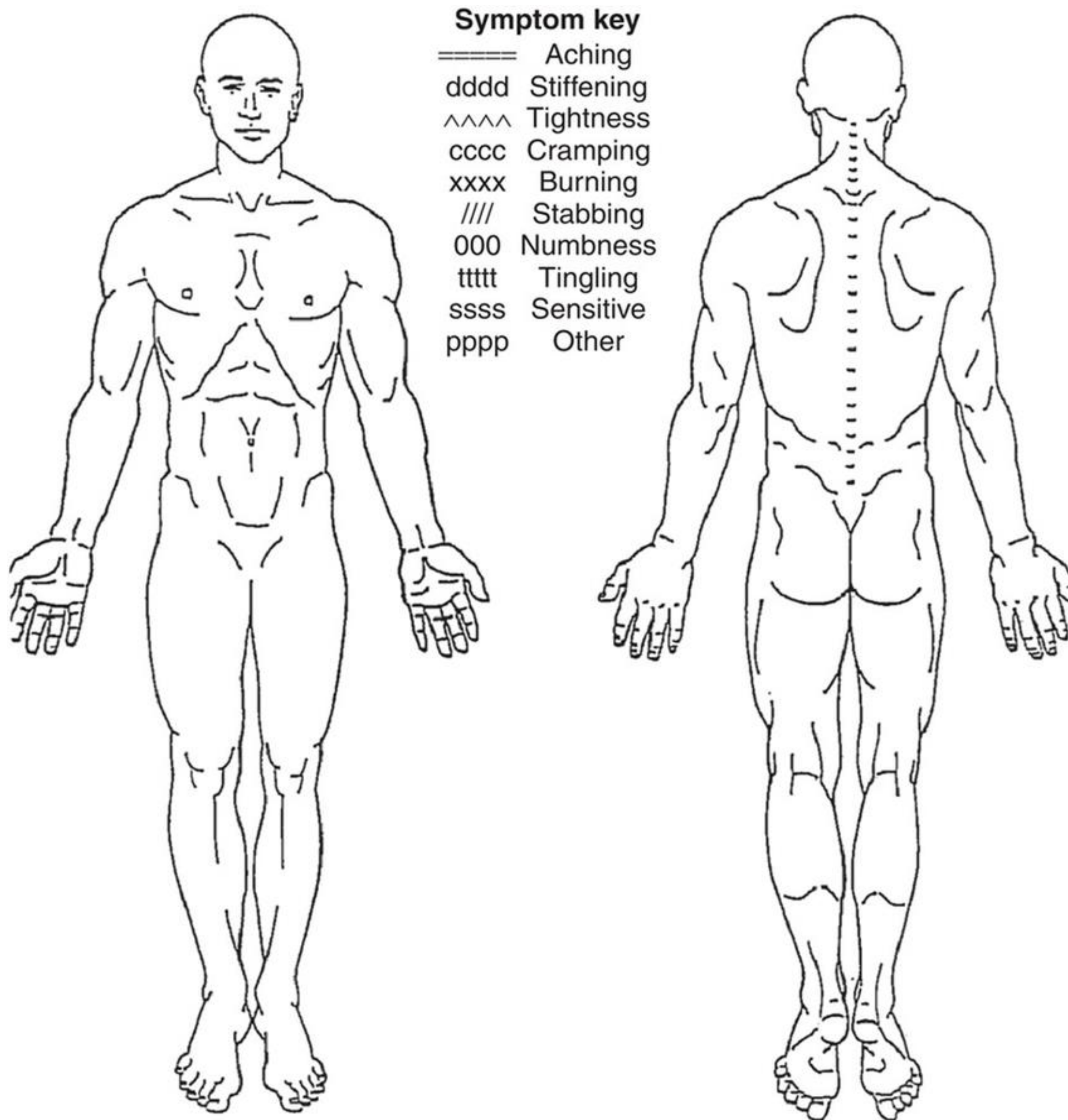
Which of the following makes your symptoms **worse**:

- ☐ Lifting
- ☐ Bending forward
- ☐ Bending backward
- ☐ Twisting Sneezing
- ☐ Straining
- ☐ Coughing
- ☐ Exercising
- ☐ Walking
- ☐ Sleeping
- ☐ Working
- ☐ Driving
- ☐ Reading
- ☐ Concentrating Dressing
- ☐ Homecare
- ☐ Playing sports
- ☐ Social Activities
- ☐ Other: _____________

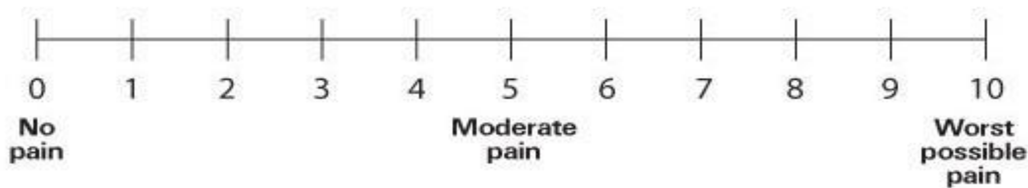
Which of the following make your symptoms **better**:

- ☐ Ice
- ☐ Heat
- ☐ Stretching
- ☐ Showering or bathing
- ☐ Exercising
- ☐ Rest
- ☐ Taking medications
- ☐ Bending a particular way
- ☐ Other: ____________

Mark the diagram below to represent where you feel your symptoms **now**:



Rate your symptoms **now**:



B. MEDICAL HISTORY

Have you had chiropractic treatment before? _________ By Whom? _________ When? _________

Surgeries you have had? ____

Any relevant injuries or illnesses? ____

Medications you currently take? ____

Date of last foot examination: ____

Check any significant medical conditions you have had:

- ☐ Migraines
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Fracture
- ☐ Cancer
- ☐ Infection
- ☐ Anemia/Blood Disorder
- ☐ Heart Disease/Stroke
- ☐ Spinal Fusions
- ☐ Sciatica/Disc Herniation
- ☐ Diabetes
- ☐ Double Jointed
- ☐ Psychological Disorder
- ☐ Depression
- ☐ Seizures
- ☐ Gastrointestinal disorder
- ☐ HIV or Hepatitis
- ☐ Other: _______________

Check any significant symptoms you have:

- ☐ Headache
- ☐ Memory Loss
- ☐ Dizziness
- ☐ Nausea
- ☐ Loss of Balance
- ☐ Clumsiness
- ☐ Body or legs want to give out
- ☐ Tingling in arms
- ☐ Tingling in legs
- ☐ Bowel or bladder control issues
- ☐ Sleep loss
- ☐ Anxiety/ Stress
- ☐ Weight gain
- ☐ Weight loss (unexplained)
- ☐ Pain at night
- ☐ Other: ____________________
- ☐ Night sweats
- ☐ Fatigue
- ☐ Diminishing Sight
- ☐ Double vision
- ☐ Blurred vision
- ☐ Pain with taking a deep breath
- ☐ Pain or unusual effort swallowing
- ☐ Difficulty speaking or slurring
- ☐ Diminished hearing
- ☐ Ringing in the ears
- ☐ Confusion
- ☐ Fainting/Blackouts
- ☐ Concussion
- ☐ Chest pain
- ☐ Stomach pain
- ☐ Pain with eating certain foods
- ☐ Menstrual issues
- ☐ Prostate or erectile issues
- ☐ Bedwetting
- ☐ Unusual stool (i.e. blood)
- ☐ Unusual cough or breathing
- ☐ Bruise easy
- ☐ On blood thinners
- ☐ Long-term steroid use