



Coastal Health Arts Clinic

27233-29A Avenue
Aldergrove, BC V4W 3J7
604-856-0333

About the Patient

NAME _____

ADDRESS _____

CITY _____ PROV _____ PCODE _____

PH (HM) _____ (WK) _____

EMAIL _____

DATE OF BIRTH _____ (M/F) _____

OCCUPATION _____

EMERGENCY CONTACT/SPOUSE _____

NAME OF MEDICAL DOCTOR/NATUROPATH _____

REFERRED BY _____

HAVE YOU HAD CHIROPRACTIC CARE BEFORE?

YES: WHEN AND BY WHOM _____

NO

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiating pain. Include all affected areas.

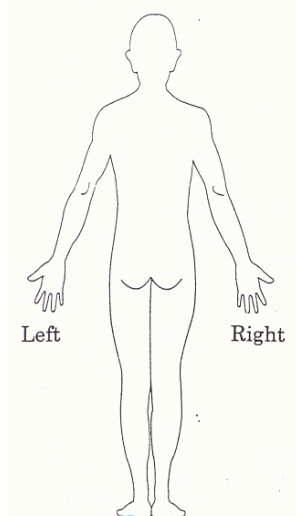
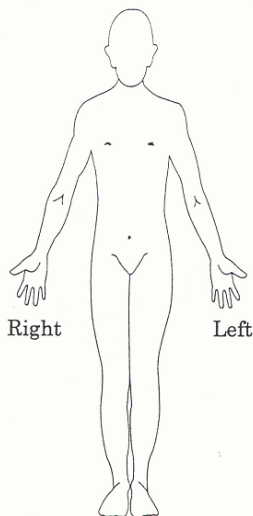
KEY: NUMBNESS
.....

PINS & NEEDLES
OOOOO

BURNING
XXXXX

ACHING

STABBING
////



On a scale of zero to 10, I rate my discomfort as follows:

Neck-Shoulder-Arm Pain

(_____)
0 10
No pain Severe pain

Mid Back Pain

(_____)
0 10
No pain Severe pain

Low Back and Leg Pain

(_____)
0 10
No pain Severe pain

Feels better with: Heat _____ Cold _____ Pressure _____ No Pressure _____

Feels worse with: Movement _____ No Movement _____ After Moving _____

Day time _____ Night time _____ Swelling _____ Color of the Area _____

Reason for the Visit

PURPOSE OF THIS VISIT/CURRENT PROBLEMS

ICBC (YES/NO) CLAIM# _____

(If YES, please ask receptionist for forms to fill out with further details)

WCB (YES/NO) CLAIM# _____

WHEN DID THIS CONDITION BEGIN?

DO YOU HAVE A PREVIOUS HISTORY OF THIS CONDITION?

YES (how long ago) _____ NO

Motor Vehicle Accidents (date & description):

Surgeries (date & description):

Serious Illness (date & description):

Falls or Fractures(date & description):

X-rays,CT scans, MRI tests (date & description):

Medications:

Nutritional Supplements (describe)

Please check each of the conditions below that you have, or had in the past even if they may seem unrelated to the present condition for which you seek treatment:

- | | |
|---|--|
| <input type="checkbox"/> Low back Pain | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Slipped Disc | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Pain in Leg | <input type="checkbox"/> Twitching of Face |
| <input type="checkbox"/> Tingling in Legs | <input type="checkbox"/> Light affects Eyes |
| <input type="checkbox"/> Pinched Nerves | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Grating in Neck | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pain in Arms | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Tingling in Arms | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Tight Shoulder Muscles | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Shoulder Blade Pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anaemia |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Enlarged Prostate |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hypoglycaemia |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Lactating | |

Do you have a Pacemaker?

Allergies (description):

Stress (High) (Medium) (Low)

Smoke (Yes) (No)

Drink alcohol (Yes) (No)

Sleep well (Yes) (No)

Headaches (Yes) (No) If Yes, describe

Bowel movements (Daily) (Yes) (No) Other

Bowel problems

(Constipation/Diarrhea/IBS/Colitis/Diverticulitis, Crohn's)

Other

Stomach function normal (Yes) (No) If No, describe

Other Therapies Used (massage, chiro, physio)

Homeopathic Remedies

Activity & Exercise regularly (Yes) (No) what kind ?

Vegetarian (Yes) (No)

Do You Eat ... (check if 'yes')

Meat (Red/White), Fish, Wheat, Dairy, Sugar, Salt,

Artificial Sweeteners, Soda, Water, Coffee, Tea

(Patient Signature)

(Date)

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