South Care Chiropractic

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**Personal Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_ Personal Health #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prov: \_\_\_\_\_\_\_\_\_\_ Post Code: \_\_\_\_\_\_\_\_\_\_\_

Telephone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell & Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By providing your email, you consent to email reminders and office related forms to be sent to you.

How did you hear about the clinic? Referral Web/Facebook Sign othe

If referral, who may we thank for recommending us to you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR HEALTH**

Have you had previous chiropractic care? Yes No When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What health issues have brought you here today? (Check one or more)

Wellness Consult Spinal Check-up Back Pain Headache Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Auto/Work Accident: ICBC WCB Please provide claim #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you are experiencing pain is it:**

Sharp  Dull  Constant  Intermittent  Radiating  **Did it occur**: Suddenly  Gradually 

|  |  |  |
| --- | --- | --- |
| Chief Complaint/Regions of Pain1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle severity of pain for each region  (1=least, 10= greatest) Neck ------------------------------- 1 2 3 4 5 6 7 8 9 10Mid Back -------------------------------  1 2 3 4 5 6 7 8 9 10 Low Back ------------------------------- 1 2 3 4 5 6 7 8 9 10 Hips ------------------------------- 1 2 3 4 5 6 7 8 9 10Arms ------------------------------- 1 2 3 4 5 6 7 8 9 10Legs ------------------------------ 1 2 3 4 5 6 7 8 9 10 | Pain Diagram Instructions:On the following diagrams, indicate all areas of:Ache ^^^^^^^^Burning + + + + +Numbness OOOOOPins and Needles ………..Stabbing ////////////Stiffness = = = = =Other XXXXXX(specify) | Picture1 |

**Since the problem started, is it: About the same  Getting Better  Getting Worse **

**What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY**

We focus on your ability to be healthy. Our first goal is to address the issues that brought you here and secondly, to offer you the opportunity of continually improving your health and wellness. Stresses can accumulate over many years and affect your health. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime:

CHILDHOOD (to age 17) YES NO UNSURE ADULTHOOD (18 to present) YES NO UNSURE

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| \*Did you have any serious falls?\*Did you play contact sports?\*Did you have any surgery?\*Was there prolonged use of medicine (e.g. inhaler, Antibiotic)?\*Were you under Chiropractic care as a child? |  |  |  | \*Do/did you smoke?\*Do/did you drink alcohol?\*Have you had any surgery?\*Were you involved in any accidents (car/work)?\*Is there any prolonged use of medicine (e.g. inhaler, Antibiotic)? |  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Please tick any symptoms that you have, even if they do not seem related to your current problem:**

|  |  |  |  |
| --- | --- | --- | --- |
| **GENERAL SYMPTOMS** | **CARDIOVASCULAR** | **GASTRO-INTESTINAL** | **WOMEN ONLY** |
| Headaches | High Blood Pressure | Belching/Gas | Birth Control |
| Pins and needles in arms | Heart Attack | Colon Problems | Hormone Replacement |
| Dizziness | Pain over Heart | Constipation | Cramps/Backache |
| Numbness in fingers | Poor Circulation | Diarrhea | Excessive Flow |
| Fatigue | Rapid Heart | Excessive Thirst | Hot Flashes |
| Sleep Disturbance | Slow Heart | Gall Bladder Problems | Vaginal Discharge |
| Wheezing | Strokes | Hemorrhoids |  |
| Digestive Issues | Swelling Ankles | Liver Problems |  |
| Depression | Varicose Veins | Nausea |  |
| **RESPIRATORY** | **EAR/NOSE/THROAT** | Abdominal Pain |  |
| Asthma | Ear ache | Ulcer |  |
| Chronic Cough | Ear noise | Poor Appetite |  |
| Breathing Difficulties | Enlarged thyroid | Poor Digestion |  |
| Spitting blood or phlegm | Frequent Colds | Vomiting |  |
| **MUSCLES AND JOINTS** | Hay Fever | Vomiting Blood |  |
| Swollen Joints | Sinusitis | Black/Bloody Stool |  |
| Stiff Joints | Sore throats | Weight Loss/Gain |  |
| **GENITO-URINARY** | Nasal Blockage | **SKIN OR ALLERGIES** |  |
| Frequent Urination | Pain behind eyes | Bruising Easily |  |
| Kidney Infection |  | Dryness |  |
| Prostate Problems |  | Eczema/Rash/Itching |  |

**Have any members of your immediate family have any of the following:**

Diabetes **** Heart problems  Kidney problems  Cancer  Back 

Place an **X** on the scale below marking where you believe your level of health and wellness is at this time.

Place an **O** on the diagram indicating where you would like your health and wellness to be.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0 – 50****Very Challenged** | **50-75****Challenged** | **75-100****Transition** | **100-125****Good** | **125+****Excellent** |