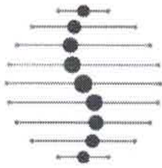


southcare
Chiropractic & Massage

512 Campbell St.
Nanaimo BC V9R 3H1
PH: 250.755.1554
FAX: 250.755.1545

Personal Information

Name: ______________________ D.O.B (MM/DD/YYYY) __________________ Personal Health# ______________

Mailing Address: _______________________________ City _____________ Province ______ Postal Code: ______

Telephone: __________________ (home) __________________ (cell) ____________________ (work)

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 Page ____ Sign ____ Other (please specify) ____________

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? ____

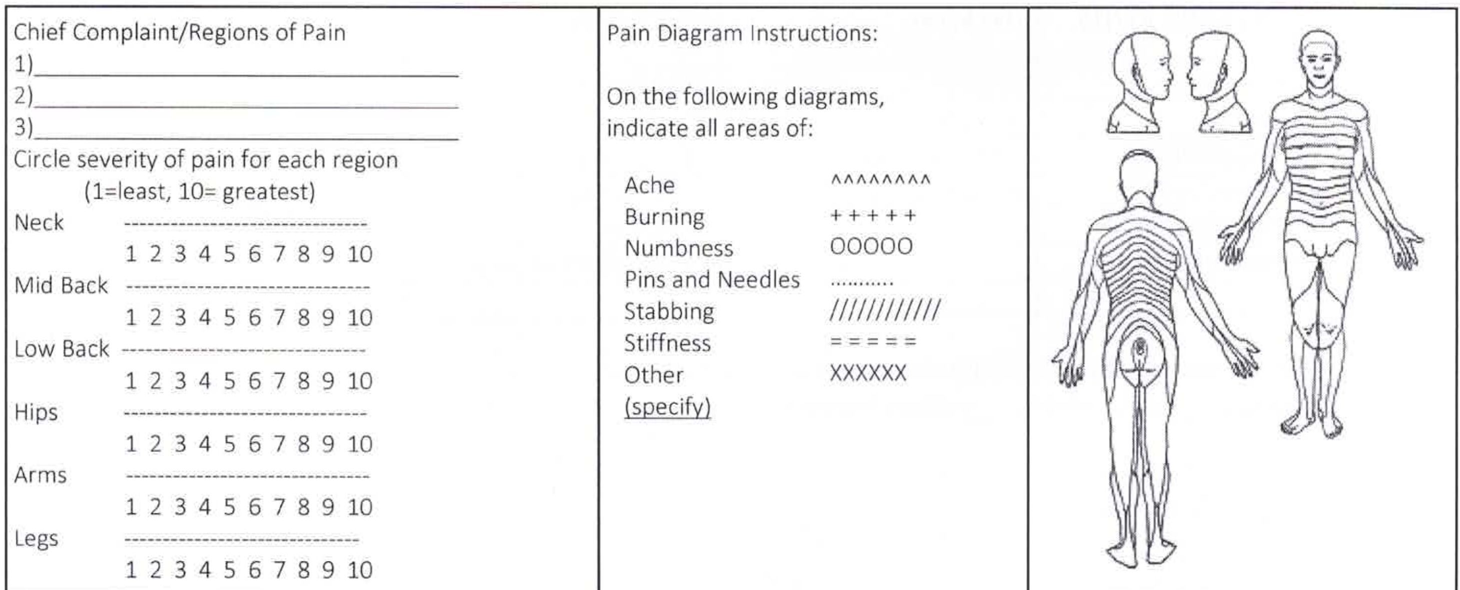
Wellness Consult ____ Spinal Check-up ____ Back Pain ____ Headache ____ Other ____

ICBC ____ WCB ____ Please Provide Claim # and Date of Accident ___________________________________

Sharp: ____ Dull ____ Intermittent ____ Radiating ____ Did the pain start: Suddenly _____ Gradually ____

Since the problem started, is it: About the same ____ Getting Better ____ Getting worse ____

What makes it worse? ____



Chief Complaint/Regions of Pain
1)_______________________________
2)_______________________________
3)_______________________________

Circle severity of pain for each region
(1=least, 10= greatest)

Region	Severity
Neck	1 2 3 4 5 6 7 8 9 10
Mid 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 10
Arms	1 2 3 4 5 6 7 8 9 10
Legs	1 2 3 4 5 6 7 8 9 10

Pain Diagram Instructions:

On the following diagrams, indicate all areas of:

Ache	^^^^^^^^
Burning	+ + + + +
Numbness	OOOOO
Pins and Needles	....
Stabbing	////////////
Stiffness	= = = = =
Other (specify)	XXXXXX

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 stressed you have focused on in your life time.

Childhood to age 17	YES	NO	NA
*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?	☐	☐	☐

Age 18 to present	YES	NO	NA
*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 ____