

Dr. Sabrina Chen-See, *Family Wellness Chiropractor*

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Welcome to our office!

Prepared for: _____

To ensure your visit with us is a pleasant one, here are the procedures you can expect today.

PAPERWORK	Complete this brief questionnaire and your health history form to help us get to know you. The Doctor will use this information to help formulate the recommendations for your care.
CONSULTATION	You will meet the Doctor. The Doctor will review your history and determine if yours is a chiropractic case. You will be informed of the cost of any office procedures before they are performed.
EXAMINATION	Standard physical, orthopedic, neurological and chiropractic tests will be performed to determine the cause(s) of your subluxation.
SPINAL IMAGES	Necessary views may be ordered to visualize the location of any spinal problems, neurological interferences, reveal any pathologies, and make your chiropractic care as precise as possible.
CORRELATION	Before proper care can be rendered, the Doctor will study your examination findings. Later, you will review your findings and receive specific care and recommendations from the Doctor.

CONFIDENTIAL PATIENT CASE HISTORY – GENERAL INFORMATION

Miss Mrs. Ms. Mr. Dr. How would you like to be addressed? _____

NAME _____ DATE _____

ADDRESS _____ CITY _____ POSTAL CODE _____

Home Phone (____) _____ Work Phone (____) _____ Ext. _____ Cell/Other (____) _____

Date of Birth (D/M/Y) ____/____/____ E-mail _____ Sex: M F Age _____

Occupation or Profession _____ Employed by _____

MARITAL STATUS Single Married Divorced Widowed Name of Medical Doctor _____

Number of Children _____ Names & Ages _____

Extended Coverage NO YES Insurance Company _____

MSP Coverage NO YES Personal Health Number _____

What is your major complaint for which you are seeking Chiropractic care? _____

Is your complaint due to a Motor Vehicle Accident? NO YES Are you claiming under the Workers' Compensation Act? NO YES

Please tell us about your attitude about your health as it is as important to us as the specific reason you've consulted our office.

Below are four prevalent health attitudes. Please mark the one that most closely reflects your personal values.

Treatment Only. I only consult a doctor when I have an ache or pain and discontinue care as soon as it has cleared up.

Maintaining Health. I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.

Prevention. In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.

Family Health. I take an active part in assisting, informing, and maintaining health, with my family. I'm concerned with the long-term effects of good health.

Thank you. We look forward to a healthy relationship with you!

Office use only:

Fee / Category _____ / _____ Diagnostic Code _____ File Number _____

Referral Source _____

Previous Chiropractic care? Yes No _____

About Your Health...

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system, that have resulted in your lowered state of health. At your report of findings, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

PRESENT HEALTH: Are you presently affected by any of the following? (within past 6 months)

O = OCCASIONAL F = FREQUENT C = CONSTANT

MUSCLE AND JOINT	O F C	GENERAL SYMPTOMS	O F C	GASTROINTESTINAL	O F C	CARDIOVASCULAR	O F C
Backache	O O O	Fever/Chills/Sweat . . .	O O O	Difficult digestion . . .	O O O	Rapid heart rate . . .	O O O
Neck Pain	O O O	Fainting	O O O	Belching or gas . . .	O O O	Slow heart rate . . .	O O O
Painful Tailbone . . .	O O O	Convulsions	O O O	Nausea or vomiting . .	O O O	High blood pressure .	O O O
Foot Trouble	O O O	Allergy	O O O	Pain over stomach . .	O O O	Low blood pressure . .	O O O
Shoulder Pain	O O O	Skin Problems	O O O	Constipation	O O O	Pain over heart	O O O
Hernia	O O O	Colds	O O O	Colon trouble	O O O	Swelling of ankles . .	O O O
Spinal Curvature . . .	O O O	Tremors	O O O	Liver trouble	O O O	Previous heart attack .	Yes O No O
Faulty Posture	O O O	Loss of Balance	O O O	Gall bladder trouble . .	O O O	Poor circulation	Yes O No O
Arthritis	O O O			Heartburn	O O O	Previous stroke	Yes O No O
STRESS SYMPTOMS		RESPIRATORY		Diarrhea	O O O	FEMALES ONLY	
Headache/Migraine . .	O O O	Chronic Cough	O O O	Bloody stools	O O O	Painful menstruation .	Yes O No O
Dizziness	O O O	Spitting up phlegm /				Excessive flow	Yes O No O
Numbness or pins & needles in		Blood	O O O	EYES, EARS, NOSE, THROAT		Irregular	Yes O No O
Arms/hands, legs/feet	O O O	Chest Pain	O O O	Deafness	O O O	Cramps or backache	Yes O No O
Ringing in the ears . .	O O O	Difficulty Breathing . .	O O O	Earache	O O O	Abnormal discharge .	Yes O No O
Blurring of vision . . .	O O O			Sore throat	O O O	Passed menopause . .	Yes O No O
Loss of sleep	O O O	URINARY		Asthma	O O O	Are you pregnant . . .	Yes O No O
Loss of concentration/		Painful Urination	O O O	Tonsillitis	O O O	Birth control pill . . .	Yes O No O
Memory	O O O	Getting up at night to		Sinus trouble	O O O		
Irritable/Nervousness .	O O O	Urinate	O O O			No. of miscarriages _____	
Depression	O O O	Blood in urine	O O O			Date of last menstrual period	
Decreased energy/		Increased urination . .	Yes O No O			_____	
Fatigue	O O O						
Tension	O O O						

PAST HEALTH: Have you ever suffered from any of the following conditions?

	YES	NO		YES	NO		YES	NO		YES	NO
Thyroid trouble	O	O	Tuberculosis	O	O	Emotional problems	O	O	Psoriasis	O	O
Diabetes	O	O	Pneumonia	O	O	Epileptic seizures. . .	O	O	Polio	O	O
High blood pressure	O	O	Back Pain	O	O	Asthma	O	O	Cancer	O	O
Heart disease	O	O	Headaches	O	O	Arthritis	O	O	Venereal disease . . .	O	O
Allergies	O	O	Stomach ulcers	O	O	Alcoholism	O	O	HIV	O	O

Please list any significant illness, operations, accidents, falls or traumas

Date	Illness / Operation / Accident / Falls

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are less than 1 in 10 million. Tests, with or without x-rays, have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this, please ask your chiropractor.

I read the above statement and consent to the performance of chiropractic examinations, adjustments and other physical therapies. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature _____

Date signed _____

