Sinclair Wellness Centre
228-757 W Hastings St
Vancouver, BC V6C 1A1
(604) 629-1120

PATIENT HEALTH HISTORY

Date ________________________

Patient's Name

____
First Middle Last

The information you provide here is essential to assist you reach your health goals. Please share as much as you feel comfortable, as everything is potentially important and feel free to ask questions.

Personal Contact Information

Address: ____
City: ______________ Province: _________Postal Code: ________________
Home tel.: ____________________work/cell________________________
(Please, circle preferred # for appointment reminders and other messages — no health information will be disclosed)
Birth date: ___________ Age: _____ Gender: M F
Number of children you have: _____
Occupation: ________________ Employer: __________________________
Employer address: ____
Care Card #: _______________________
Is this an ICBC Case? Y N Is this a WCB Case? Y N
Marital status: Single Married Partnership Separated Divorced
With whom do you live?
Spouse Partner Parents Friends Children Alone
Email _________________________________
Do you wish to receive our health email? Y N
How did you find us?____

Physician/Emergency Contact Information

Do you see a medical doctor? Y N
Name: ____________________ Tel.: _____________ Fax: ______________
Emergency Contact: ___________ Relationship: _________Tel:_____________

Chief Complaint

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A = Ache
B = Burning
N = Numbness
O = Other
P = Pins & Needles
S = Stabbing

Please provide any further details.

____
____
____
____
____
____
____

Medical History

Have you been treated for any conditions in the last year? Y N
If yes, please describe:

____

Date of last physical exam: ______________________________
Is there a chance that you are pregnant? Y N
Have you had any of the following taken? MRI X-rays CT Scans
If yes, where? ______________________________________
Date: ____
Have you had any of the following tests done?
Blood Urine Bone scan Other: ____________________
Most Recent - Date: _________________________________

Immunizations:

Tetanus Pertussis Diphtheria German measles Measles Mumps Polio

Any reactions to the immunizations?

____

Childhood Illnesses:

Measles	Mumps	Chickenpox	Tuberculosis	Diabetes
Cancer	Rheumatic Fever	Scarlet Fever	German Measles	Ear/Throat infections

Hospitalizations & Surgeries:
If you have ever been hospitalized, list reason, and dates:

____

____

____

Symptoms	**Yes**	**No**
Do you experience pain every day?		
Do your symptoms interfere with daily life?		
Does pain wake you up at night?		
Are your symptoms worse during certain times of the day?		
Do changes in weather affect your symptoms?		
Do you wear orthotics?		
Do you take vitamin supplements?		

What activities aggravate your symptoms?
e.g. ____

Adult Illnesses/Injuries:
List all serious diseases & injuries for which you have not been hospitalized, including approximate dates:

____

____

____

Habits:	**None**	**Light**	**Moderate**	**Heavy**
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
Soft Drinks				
Water				
Salty Foods				
Sweet Foods				
Artificial Sweeteners				

Medications:
List all medications that you are or have taken on a regular basis in the last 6 months (include home remedies):
A) ____________________ D) ____________________
B) ____________________ E) ____________________
C) ____________________ F) ____________________

Medications to which you are allergic:
A) ____________________ D) ____________________
B) ____________________ E) ____________________
C) ____________________ F) ____________________

Family History:
Do you have a family history of any of the following?

Anemia	Diabetes	Hay fever/hives	Liver disease
Arthritis	Epilepsy	autoimmune disease	Mental illness
Asthma	Polio	Gallbladder disease	Stroke
Cancer	Glaucoma	High blood pressure	Tuberculosis
Cataracts	Goiter	Kidney disease	Heart disease

Father still living? Y Age N Age at time of death ___ Cause of death__________

Mother still living? Y Age N Age at time of death ___ Cause of death __________

Sibling still living? Y Age N Age at time of death ___ Cause of death __________

Sibling still living? Y Age N Age at time of death ___ Cause of death __________

Review of Systems
Y = Yes, Present Condition N = No, Never had the Condition P = Problem of the Past

Habits

Alcoholism	Y	P	N	Anorexia/Bulimia	Y	P	N
Overeating	Y	P	N	Over-the-Counter Drugs	Y	P	N
Smoking	Y	P	N	Recreational Drugs	Y	P	N

e.g. ____

Head

Headaches	Y	P	N	Migraine Headaches	Y	P	N
Head Injury	Y	P	N	Jaw/TMJ Problems	Y	P	N

Ears

Ringing	Y	P	N	Dizziness	Y	P	N
Earaches	Y	P	N	Impaired Hearing	Y	P	N

Neck

Lumps	Y	P	N	Swollen Glands	Y	P	N
Goiter	Y	P	N	Pain or Stiffness	Y	P	N

Skin

Rashes	Y	P	N	Psoriasis	Y	P	N
Lumps	Y	P	N	Acne/Boils	Y	P	N
Itching	Y	P	N	Loss of Hair	Y	P	N
Eczema/Hives	Y	P	N	Color Changes	Y	P	N
Psoriasis	Y	P	N	Bruise Easily	Y	P	N

Musculoskeletal

Joint Pain	Y	P	N	Muscle Spasms	Y	P	N
Weakness	Y	P	N	Sciatica	Y	P	N
Arthritis	Y	P	N	Broken Bones	Y	P	N
Poor Posture	Y	P	N	Spinal Curvatures	Y	P	N
Back Pain	Y	P	N	Knee/Foot	Y	P	N

Eyes

Blurred Vision	Y	P	N	Cataracts	Y	P	N
Glasses	Y	P	N	Eye Pain/Strain	Y	P	N
Glaucoma	Y	P	N	Tearing/Dryness	Y	P	N
Spots in Eyes	Y	P	N	Color Blind	Y	P	N
Double Vision	Y	P	N	Dizziness	Y	P	N

Nose/Sinuses

Stuffiness	Y	P	N	Loss of Smell	Y	P	N
Sinus pain	Y	P	N	Hay fever	Y	P	N
Nose Bleeds	Y	P	N	Frequent Colds	Y	P	N

Mouth/Throat

Hoarseness	Y	P	N	Gum Problems	Y	P	N
Sore Throat	Y	P	N	Jaw Clicks	Y	P	N
Cavities	Y	P	N	Sore Lips/Tongue	Y	P	N
Loss of Taste	Y	P	N				

Respiratory

Asthma	Y	P	N	Wheezing	Y	P	N
Cough	Y	P	N	Coughing up Blood	Y	P	N
Bronchitis	Y	P	N	Difficulty Breathing	Y	P	N
Sputum	Y	P	N	Painful Breathing	Y	P	N
Pneumonia	Y	P	N	Emphysema	Y	P	N
Pleurisy	Y	P	N	Shortness of Breath (SOB)	Y	P	N
Tuberculosis	Y	P	N	SOB Lying Down	Y	P	N
SOB at Night	Y	P	N				

Cardiovascular

Angina	Y	P	N	Irregular Heartbeat	Y	P	N
Blood Clots	Y	P	N	Arteriosclerosis	Y	P	N
Heart Disease	Y	P	N	Rheumatic Fever	Y	P	N
Fainting	Y	P	N	Ankle Swelling	Y	P	N
Pacemaker	Y	P	N	Low Blood Pressure	Y	P	N
Chest Pain	Y	P	N	High Blood Pressure	Y	P	N
Stroke	Y	P	N				

Gastrointestinal

Diarrhea	Y	P	N	Gallbladder disease	Y	P	N
Ulcers	Y	P	N	Changes in Thirst	Y	P	N
Black Stool	Y	P	N	Spitting up Blood	Y	P	N
Jaundice	Y	P	N	Hemorrhoids	Y	P	N
Constipation	Y	P	N	Abdominal Pain	Y	P	N
Heartburn	Y	P	N	Blood in Stool	Y	P	N
Liver Disease	Y	P	N	How many bowel movements per day? ______			

Urinary

Incontinence	Y	P	N	Frequent Infections	Y	P	N
Kidney Stones	Y	P	N	Painful Urination	Y	P	N
Cloudy/Smelly	Y	P	N	Frequent at Night	Y	P	N

Blood/Peripheral Vascular

Anemia	Y	P	N	Cold Hands/Feet	Y	P	N
Leg Pain	Y	P	N	Thrombophlebitis	Y	P	N
Easy Bruising	Y	P	N	Varicose Veins	Y	P	N

Neurological

Fainting	Y	P	N	Paralysis	Y	P	N
Numbness	Y	P	N	Muscle Weakness	Y	P	N
Seizures	Y	P	N	Loss of Memory	Y	P	N
Tingling	Y	P	N	Loss of Balance	Y	P	N

Emotional

Mood Swings	Y	P	N	Fatigue	Y	P	N
Stress	Y	P	N	Anxiety	Y	P	N
Depression	Y	P	N	Sleep Problems/Insomnia	Y	P	N

Endocrine

Hypothyroid	Y	P	N	Cold Intolerance	Y	P	N
Hot Flashes	Y	P	N	Excessive Hunger	Y	P	N
Hyperthyroid	Y	P	N	Excessive Thirst	Y	P	N

Male Reproductive

Hernias	Y	P	N	Testicular Masses	Y	P	N
Discharge	Y	P	N	Sexual Difficulty	Y	P	N
Prostate	Y	P	N	Frequent Urination at Night	Y	P	N
				Premature Ejaculation	Y	P	N
				Testicular Pain	Y	P	N
				Venereal Disease	Y	P	N

Female Reproductive

Age of First Menses ___________ Age of Last Menses (if menopausal) __________

Length of Cycle ________

Duration of Menses ___________ Date of Last Annual Exam ___________________

Painful Menses	Y	P	N	Do Self Breast Exams	Y	P	N
Night Sweats	Y	P	N	Endometriosis	Y	P	N
Ovarian Cysts	Y	P	N	Sexual Difficulty	Y	P	N
Fertility Issues	Y	P	N	Cervical Dysplasia	Y	P	N
Breasts Tender	Y	P	N	Venereal Disease	Y	P	N
Sexually Active	Y	P	N	Bleeding between Cycles	Y	P	N
Heavy Flow	Y	P	N	Abnormal Pap	Y	P	N
PMS	Y	P	N	Breast Lump(s)	Y	P	N
Nipple Discharge	Y	P	N	Irregular Cycle	Y	P	N
Birth Control	Y	P	N				

If yes, what type? _____________________________

# of Pregnancies: ___ # of Live Births: ___

# of Miscarriages:___# of Abortions: ___

What is your personal definition of Optimal Health?

____

____

In terms of your health, what goal(s) do you wish to achieve by coming to our clinic for treatment?

____

____

____

Insurance Information

Extended health insurance? Y N
Name of Company: ____
Provider #: ____
(Unless specified by your check mark, all information is available to all practitioners in the office.)

Chiropractor	Acupuncturist	Massage Therapist
Physiotherapist	Naturopath	Other: ___________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Further more, I understand that this office will complete any necessary forms to assist me in making collection from my insurance carrier and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I also give this office power of attorney to endorse insurance cheques made out to me, to be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also understand that 24 hours notice is needed for cancellation of appointments and that the full fee may be charged and paid for prior to my next appointment.

Fees 30 min. Session $90 15 min. Session $55 First Visit $90

Re-Exam $55

Patient Signature or Guardian's Signature Authorizing Care:

____

Date: ______________________________

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

____
Name (Please Print)

____________________________________ Date: ______________ 20____
Signature of patient (or legal guardian)

____________________________________ Date: _______________20____
Signature of Chiropractor