# WELCOME TO KLO CHIROPRACTIC

NAME: ______________________________ DATE: ______________________

DATE OF BIRTH: DD / MM / YYYY________ AGE: _____ BC HEALTH CARE #: ______________________

ADDRESS: ______________________________ EXTENDED HEALTH PLAN: Y/N

POSTAL CODE: ______________ CITY: ____________________ PHONE: (Home) ______________________

EMAIL: ______________________________ (Work)______________________

OCCUPATION: ______________________________ (Cell) ______________________

MARITAL STATUS:____________________ CHILDREN :______________________________

Whom may we contact in case of an emergency? ______________________________ Phone: ________________

**Name** of Family Doctor:______________ Chiropractor:______________ Physio:____________________
Massage Therapist:________________ Naturopath:________________

HOW DID YOU HEAR ABOUT THE CLINIC? (please circle one)
Website Yellow Pages Daily Courier Newspaper (name__________) Doctor (name:______________________)
Patient/Friend (name:____________________) Walk-in Other (where/who:____________________)

**Is the reason you came to this office related to a:**

A) Motor Vehicle Accident? YES NO **Date of loss:** MM / DD / YYYY
B) Work-related injury (WCB)? YES NO **Date of loss:** MM / DD / YYYY

**When did your symptoms start?** ______________________________

**Describe your symptoms and how they began:** ______________________________

______________________________

**How often do you experience your symptoms?**

- ☐ Constantly (76 - 100% of the day)
- ☐ Frequently (51 - 75% of the day)
- ☐ Occasionally (26 - 50% of the day)
- ☐ Intermittently (0 - 25% of the day)

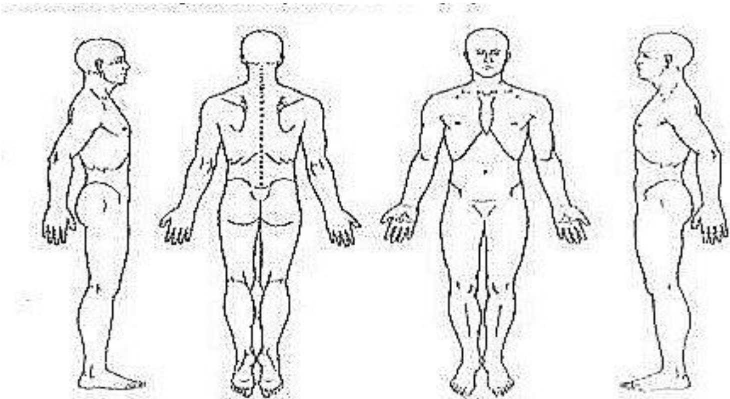
**What describes the nature of your symptoms?**

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

**How are your symptoms changing?**

- ☐ Getting better
- ☐ Not changing
- ☐ Getting worse

**Indicate where you have pain or other symptoms:**



**How bad are your symptoms at their:**

| | *none* | | | | | | | | | | *unbearable* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **worst:** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **best:** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**How do your symptoms affect your ability to perform daily activities?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| *no complaints* | | | *mild, forgotten with activity* | | *moderate, interferes with activity* | | *limiting, prevents full activity* | | *intense, preoccupied with seeking relief* | *severe, no activity possible* |

**Who have you seen for your current symptoms?**

- ☐ No one ☐ Medical Doctor ☐ Other
- ☐ Chiropractor ☐ Acupuncturist ☐ Massage Therapist

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**What activities make your symptoms worse?** ______________________________

**What activities make your symptoms better?** ______________________________

**What tests have you had for your symptoms and when were they performed?**

☐ X-Ray: ____________ (date) ☐ MRI : ____________ (date) ☐ CT Scan: ____________ (date) ☐ Other: ____________ (date)

**What do you hope to get from your treatment?** (select all that apply):

☐ Reduce symptoms
☐ Resume/ increase activity
☐ Explanation of condition
☐ Learn how to care for this on my own
☐ How to prevent this

**What type of regular exercise do you perform?** ☐ None ☐ Light ☐ Moderate ☐ Strenuous

**Number of Alcoholic Drinks per week:**____________ **Height:**____________**Weight:**____________

**How has your sleep been?** Before condition (Excellent/Good/Poor) Since condition started? (Excellent/Good/Poor)

**For each of the conditions listed below, place a check in the *"Past"* column if you have had the condition in the past. If you presently have a condition listed below, place a check in the *"Present"* column.**

| Past | Present | | Past | Present | | Past | Present | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Headaches | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Neck Pain | ☐ | ☐ | Heart Attack | ☐ | ☐ | Excessive Thirst |
| ☐ | ☐ | Upper Back Pain | ☐ | ☐ | Chest Pains | ☐ | ☐ | Frequent Urination |
| ☐ | ☐ | Mid Back Pain | ☐ | ☐ | Stroke | | | |
| ☐ | ☐ | Low Back Pain | ☐ | ☐ | Angina | ☐ | ☐ | Smoking/use of tobacco products |
| ☐ | ☐ | Shoulder Pain | ☐ | ☐ | Kidney Stones | ☐ | ☐ | Allergies |
| ☐ | ☐ | Elbow/Upper Arm Pain | ☐ | ☐ | Kidney Disorders | ☐ | ☐ | Depression |
| ☐ | ☐ | Wrist Pain | ☐ | ☐ | Bladder Infection | ☐ | ☐ | Systemic Lupus |
| ☐ | ☐ | Hand Pain | ☐ | ☐ | Painful Urination | ☐ | ☐ | Epilepsy |
| | | | ☐ | ☐ | Loss of Bladder Control | ☐ | ☐ | Dermatitis/Eczema/Rash |
| ☐ | ☐ | Hip/Upper Leg Pain | ☐ | ☐ | Prostate Problems | ☐ | ☐ | HIV/AIDS |
| ☐ | ☐ | Knee/Lower Leg Pain | | | | | | |
| ☐ | ☐ | Ankle/Foot Pain | ☐ | ☐ | Abnormal Weight Gain/Loss | | | |
| | | | ☐ | ☐ | Loss of Appetite | **Females Only:** | | |
| ☐ | ☐ | Jaw Pain | ☐ | ☐ | Abdominal Pain | | | |
| | | | ☐ | ☐ | Ulcer | ☐ | ☐ | Birth Control |
| ☐ | ☐ | Joint Swelling/Stiffness | ☐ | ☐ | Hepatitis | ☐ | ☐ | Hormonal Replacement |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Liver/Gall Bladder Disorder | ☐ | ☐ | Pregnancy |
| ☐ | ☐ | Rheumatoid Arthritis | | | | | | |
| | | | ☐ | ☐ | Cancer | | | |
| ☐ | ☐ | General Fatigue | ☐ | ☐ | Tumor | | | |
| ☐ | ☐ | Dizziness | ☐ | ☐ | Asthma | | | |
| ☐ | ☐ | Visual Disturbances | ☐ | ☐ | Chronic Sinusitis | | | |

**Indicate if an immediate family member has had any of the following:**

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ Other: ____________

**List all prescriptions and over-the-counter medications and nutritional/herbal supplements you are taking:**

______________________________

______________________________

**List all the surgical procedures you have had and the times you have been hospitalized:**

______________________________

______________________________