

Name :(Last) _____ (First) _____ (Middle Initial) _____

BC Care Card #: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone # (Home): _____ Alt. #: _____

E-mail Address: _____

Date of Birth: (day) / (month) / (year) Age: _____ Gender: Female _____ Male _____

Marital Status: S M W D (circle one) # of Children: _____

Occupation: _____ Retired: _____

Employer: _____ Work #: _____

Work Address: _____

Next of Kin or other to reach in case of an emergency: _____

Relationship: _____ Phone #: _____

MEDICAL DOCTOR:

Name: _____ Telephone: _____

Address: _____

Date of Last Appointment: _____ Date of Last Physical: _____

Date of last Dental Examination: _____

How did you hear about our clinic? _____

Who referred you to our office? (name) _____ (relationship) _____

Has any other family member already been a patient at the clinic? _____

CONTEXT OF CARE REVIEW

Successful health care and preventative medicine are possible only when we have a complete understanding of the patient physically, mentally, and emotionally. The nature of your responses to the following questions will go a long way in assisting our understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid us in assisting your health needs.

1) Why did you choose to come to this clinic?

- What do you know about our approach?

2) What three expectations do you have from this visit to our clinic?

- What long term expectations do you have from working with our clinic?
- What expectations do you have of the provider you are seeing today?

3) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

4) a) What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviours or lifestyle habits do you currently engage in regularly that you believe are less constructive lifestyle habits? (please list)

5) What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that we will be sharing with you?

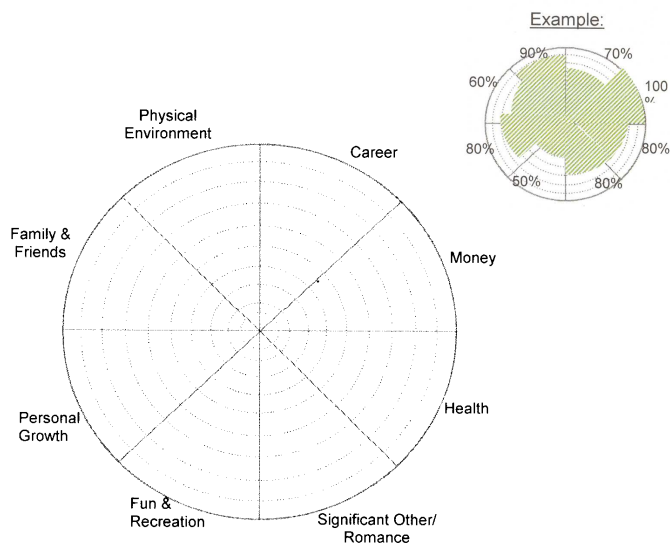
6) Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for the career.

Do the same for each area, starting from the center point radiating outwards.



What are your most important health problems? List as many as you can in order of importance:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____

FAMILY HISTORY

Do you have a family history of any of the following? (please circle)

- | | | | |
|-----------------------|----------|---------------|---------------------|
| Cancer | Diabetes | Heart Disease | High Blood Pressure |
| Kidney Disease | Epilepsy | Arthritis | Glaucoma |
| Tuberculosis | Stroke | Anemia | Mental Illness |
| Asthma/Hayfever/Hives | | | |

Any other relevant family history? _____

Allergies

Are you hypersensitive or allergic to...

Drugs? _____

Foods? _____

Environmental or chemical? _____

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-Rays, CT scans, EEG, EKG's have you had?

_____	year: _____	_____	year: _____
_____	year: _____	_____	year: _____
_____	year: _____	_____	year: _____

Current Medications & Supplements

Do you take or use? (Circle Yes or No)

Pain Relievers	Y N	Laxatives	Y N	Antibiotics	Y N
Appetite Suppressants	Y N	Cortisone	Y N	Tranquilizers	Y N
Thyroid Medication	Y N	Sleeping Pills	Y N	Antacids	Y N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking:

- 1) _____ 5) _____
- 2) _____ 6) _____
- 3) _____ 7) _____
- 4) _____ 8) _____

PRIOR CARE BY CONSERVATIVE HEALTHCARE: (Chiropractic / Naturopath / Massage / Other)

Name: _____ Telephone: _____

Results: Excellent Good Fair Poor

X-Rays taken: Yes No Date: _____

TRAUMA(s):

Falls and Accidents – list: _____

Scars – list: _____

Surgery recommended but not performed – list: _____

Have you ever been knocked unconscious: Yes No Don't Know

If so, for how long: _____

GENERAL

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.

Maximum Weight: _____ When: _____

When during the day is your energy the best? _____ Worst? _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

REVIEW OF SYSTEMS

Y = A condition you have now

N = Never had

P = Significant problem in the past

Mental / Emotional

Treated for emotional problems	Y N P	Depression	Y N P
Mood swings	Y N P	Anxiety or nervousness	Y N P
Considered/Attempted suicide	Y N P	Tension	Y N P
Poor concentration	Y N P	Memory problems	Y N P

Immune

Reactions to immunizations	Y N P	Reactions to vaccinations	Y N P
Chronic Fatigue Syndrome	Y N P	Chronic infections	Y N P
Chronically swollen glands	Y N P	Slow wound healing	Y N P

Endocrine

Hypothyroid	Y N P	Heat or cold intolerance	Y N P
Hypoglycemia	Y N P	Diabetes	Y N P
Excessive thirst	Y N P	Excessive hunger	Y N P
Fatigue	Y N P	Seasonal depression	Y N P

Neurologic

Seizures	Y N P	Paralysis	Y N P
Muscle weakness	Y N P	Numbness or tingling	Y N P
Loss of memory	Y N P	Easily Stressed	Y N P
Vertigo or dizziness	Y N P	Loss of balance	Y N P

Skin

Rashes	Y N P	Eczema, Hives	Y N P
Acne, Boils	Y N P	Itching	Y N P
Colour change	Y N P	Perpetual hair loss	Y N P
Lumps	Y N P	Night sweats	Y N P

Head

Headaches	Y N P	Head injury	Y N P
Migraines	Y N P	Jaw/TMJ problems	Y N P

Eyes

Spots in eyes	Y N P	Cataracts	Y N P
Impaired vision	Y N P	Glasses or contacts	Y N P
Blurriness	Y N P	Eye pain/strain	Y N P
Colour blindness	Y N P	Tearing or dryness	Y N P
Double vision	Y N P	Glaucoma	Y N P

Ears

Impaired hearing	Y N P	Ringing	Y N P
Earaches	Y N P	Dizziness	Y N P

Nose and Sinuses

Frequent colds	Y N P	Nose bleeds	Y N P
Stuffiness	Y N P	Hayfever	Y N P
Sinus problem	Y N P	Loss of smell	Y N P

Mouth and Throat

Frequent sore throat	Y N P	Copious saliva	Y N P
Teeth grinding	Y N P	Sore tongue/lips	Y N P
Gum problems	Y N P	Hoarseness	Y N P
Dental cavities	Y N P	Jaw clicks	Y N P

Neck

Lumps	Y N P	Swollen glands	Y N P
Goiter	Y N P	Pain or stiffness	Y N P

Respiratory

Cough	Y N P	Sputum	Y N P
Spitting up blood	Y N P	Wheezing	Y N P
Asthma	Y N P	Bronchitis	Y N P
Pneumonia	Y N P	Pleurisy	Y N P
Emphysema	Y N P	Difficulty breathing	Y N P
Pain on breathing	Y N P	Shortness of breath	Y N P
Shortness of breath at night	Y N P	Shortness of breath lying down	Y N P

Cardiovascular

Heart disease	Y N P	Angina	Y N P
High/Low blood pressure	Y N P	Murmurs	Y N P
Blood clots	Y N P	Fainting	Y N P
Phlebitis	Y N P	Palpitations/Fluttering	Y N P
Rheumatic fever	Y N P	Chest pain	Y N P
Swelling in ankles	Y N P		

Gastrointestinal

Trouble swallowing?	Y N P	Heartburn	Y N P
Change in thirst	Y N P	Abdominal pain or cramps	Y N P
Change in appetite	Y N P	Belching or passing gas	Y N P
Nausea/vomiting	Y N P	Constipation?	Y N P
Ulcer	Y N P	Diarrhea	Y N P
Jaundice (yellow skin)	Y N P	Bowel movements: how often? _____	
Gall bladder disease	Y N P	→ Is this a change? _____	
Liver disease	Y N P	Black stool	Y N P
Hemorrhoids	Y N P	Blood in stool	Y N P

Urinary

Pain on urination	Y N P	Increase frequency	Y N P
Frequency at night	Y N P	Inability to hold urine	Y N P
Frequent infections	Y N P	Kidney stones	Y N P

Musculoskeletal

Joint pain or stiffness	Y N P	Arthritis	Y N P
Broken bones	Y N P	Weakness	Y N P
Muscle spasms or cramps	Y N P	Sciatica	Y N P

Blood/Peripheral Vascular

Easy bleeding or bruising	Y N P	Anemia	Y N P
Deep leg pain	Y N P	Cold hand/feet	Y N P
Varicose veins	Y N P	Thrombophlebitis	Y N P

Male Reproduction

Hernias	Y N P	Testicular masses	Y N P
Testicular pain	Y N P	Prostate disease	Y N P
Venereal disease	Y N P	Discharge or sores	Y N P
Are you sexually active	Y N	Chlamydia	Y N P
Sexual Orientation: _____		Gonorrhea	Y N P
Impotence	Y N P	Condyloma	Y N P
Premature ejaculation	Y N P	Herpes	Y N P
Birth Control? Type? _____		Syphilis	Y N P

Female Reproduction / Breasts

Age of first menses _____		Date of last annual exam / PAP _____	
Age of last menses (if menopausal) _____		→ Are cycles regular?	Y N
Length of cycle _____ days		Bleeding between cycles	Y N P
Duration of menses _____ days		Pain during intercourse	Y N P
Painful menses	Y N P	Clotting	Y N P
Heavy or excessive flow	Y N P	Discharge	Y N P
PMS	Y N P	Birth control	Y N P
If yes, what are your symptoms _____		→ What type _____	
_____		Number of pregnancies: _____	
Endometriosis	Y N P	Number of live births: _____	
Ovarian cysts	Y N P	Number of miscarriages: _____	
Difficulty conceiving	Y N P	Number of abortions: _____	
Cervical Dysplasia	Y N P	Menopausal symptoms	Y N P
Sexual difficulties	Y N P	Abnormal PAP	Y N P
Gonorrhea	Y N P	Chlamydia	Y N P
Herpes	Y N P	Condyloma	Y N P
Are you sexually active	Y N	Syphilis	Y N P
Sexual Orientation: _____		Breast lumps	Y N P
Do you do self breast exams	Y N P	Nipple discharge	Y N P
Breast pain/tenderness	Y N P		

Is there anything else you would like to add or comment on?

**Thank you for your time and effort.
Our team looks forward to providing you with the best possible care.**