

CLINIC INFORMATION

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 #: _____

Please Note: your appointment time has been reserved for you. In courtesy of your practitioner & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated practitioners to collect my personal information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any time of the contact numbers I have provided above. In addition, I authorize the clinic and its associated practitioners to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Patient Signature: _____

Date Signed: _____

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) What is your primary health concern; and why are you here?

- 2) Why Did you choose to come to Port Moody Integrated Health?
 - Do you know anything about our approach?

- 3) What short expectations do you have from this visit to Port Moody Integrated Health?
 - What long term expectations do you have if any, from working with Port Moody Integrated Health?

- 4) 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% |
|----|---|---|---|---|---|---|---|---|---|---|----|------|

- 5)
 - 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)

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

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

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: _____

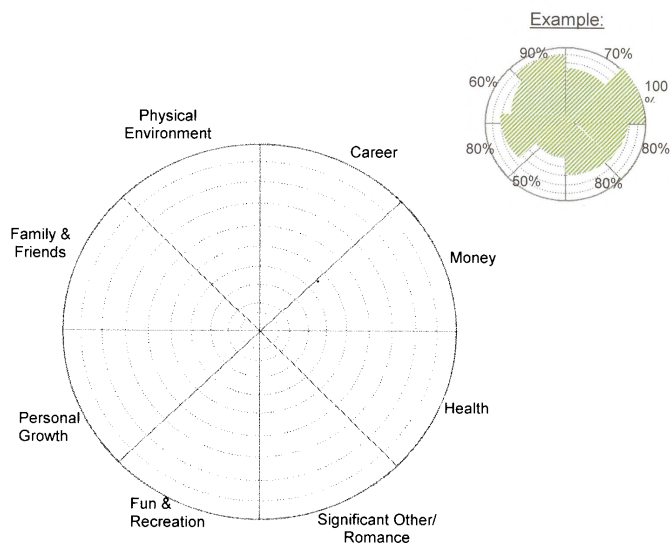
To Drink: _____

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: _____ |

