WELCOME TO ALL CARE CHIROPRACTIC

Please fill out the following information to the best of your knowledge. It is understood that you may not recall all relevant information at this time.

Last Name _____ First _____ Initial _____

B.C. MSP Care Card #_____ Female _____ Male _____

Birth Date M ____ D____ Y____ Age _____ Marital Status _____ No. of Children ____

Address_____ City _____ Postal code _____

Home# (____)_____ Work# (_____)_____ Cell# (____)_____

E-mail Address _____

Preferred appointment confirmation? (Circle one) Text - Email - Phone
What is your cell provider? (If text confirmation circled) _____

Occupation _____ Employer _____

Who can we thank for referring you to our office? _____

Did you use any of the following to find out about our office: (Please Circle)
YellowPages - Online - Office Website - CanPages - Phone Book - Other_____

Health History

Chiropractic focuses on function and not disease, you and your family do not need to have any symptoms to benefit from care.
Is your visit today for a Spinal Check-up or a Specific Complaint?(Please Circle)
Please describe your main concern.

_____

Are you experiencing numbness anywhere? If yes, list the area(s)

_____

When did the first symptom of the above concern arise?

_____

Is this a Work Safe BC Claim? (work related injury) Y (see WCB form) N

Is this an ICBC claim? (motor vehicle accident) Y (see ICBC form) N

Is there a specific event which caused your concern?

_____

Have you had this problem before? If yes, when_____

Does this problem run in the family? _____

What activities aggravate your symptoms?

_____

Are you currently taking any medications for this problem?

_____

What other treatments, if any, have you tried for this problem?

_____

Did you find the treatments to be effective? _____

Do you have any other concerns?_____

Are you generally healthy? Y N

Have you ever had surgery? Y N

If yes, please describe _____

_____

Have you been diagnosed with any medical conditions? Y N
If yes, please describe _____

Are you now using prescription drugs? Y N
Please list your current medications_____
Please list past medications_____

Have you ever been involved in a motor vehicle accident? Y N
When _____
Describe_____

Have you ever had any broken bones? Y N
Describe _____

Do you have any allergies? Y N
If yes, please list _____

Do you wear orthotics? Y N If yes, for how many years? _____

Do you take any vitamins? Y N
If yes, please list_____

For women: Have you ever been pregnant? Y N How many times _____
Are you currently pregnant? Y N If yes, how many months _____

Please circle other problem areas

Headaches	hip	thyroid	stomach	kidney
Migraines	knee	collar bone	skin	dizzy
Neck	leg	asthma	circulation	colic
Jaw	foot	vision	liver	sinus
Shoulder	allergies	reproduction	bladder	elbows
Arm	hearing	pancreas	poor sleep	ribs
Hand	pelvis	lungs	intestines	ankles
Upper back	digestion	gall bladder	blood sugar	hands
Mid back	heart	blood pressure	immune system	
low back	wrist	carpal tunnel		

Nervous system: anxiety, panic attacks, epilepsy, _____

Difficulty walking/sitting		weakness	Frequent Colds/Flu
Indigestion	stress	ringing in ears	depression
Fatigue	diarrhea	constipation	moody/irritable
Lack of concentration		menopausal difficulties	
Poor memory	menstrual difficulties		joint pain/stiffness

Feet: bunions plantar fascitis (heel spurs) shin splints hammertoes

Chiropractic History

Last Family Chiropractor_____

Previous visit _____ How long under care _____

Have you been on a Chiropractic Maintenance Program? Yes No

Please check box you are currently committed to:

☐ **I am willing to make LIFESTYLE changes to improve my general health**

☐ **I would like a PREVENTION program to stop my problem from returning**

☐ **I would like to CORRECT the underlying problem**

☐ **I just want symptom relief**

FAMILY HISTORY

Please list all genetic diseases, major illnesses, or problems for each of the following family members:

Mother _____

Father _____

Siblings _____

Maternal Grandparents _____

Paternal Grandparents _____

Name of Practitioner	Condition(s) being treated
Acupuncturist _____	_____
Massage Therapist _____	_____
Medical Doctor _____	_____
Physio Therapist _____	_____
Naturopathic Doctor _____	_____

_____

Please circle the appropriate billing method:
PRIVATE / ICBC / WCB / DVA / RCMP / MILITARY

By my signature below, I authorize the collection, use and disclosure of personal information, as defined in the Personal Information and Privacy Act (PIPA), required for treatment and/or any related administrative purpose. I understand that all my personal information is confidential, and must be treated in accordance with PIPA.

Signature _____ **Date** _____