# Patient Intake Form

Date: _____

**Please fill out our confidential Patient Health Record completely and accurately.**
**If you have any questions, please don't hesitate to ask your practitioner.**

## PERSONAL INFORMATION

Name: _____
BC Medical #: _____
Birthdate (mm/dd/yyyy): _____ /_____ / _____
Age: _____ Gender: Male ☐ Female ☐
Address: _____
City: _____ Prov: _____ Postal: _____
Occupation: _____
Home #: _____ Work #: _____
Mobile #: _____
Email: _____

Emergency Contact: _____
Phone #: _____
Did a health care practitioner refer you?
Yes ☐ No ☐

If yes, please provide the following:
Name: _____
Phone #: _____

Current Medical Practitioner: _____
Phone #: _____
Date of last physical examination? _____

Briefly describe your main concern(s):
_____
_____
Overall, how is your general health?
_____
_____
List of current medications:
_____
_____
_____

## REASON(S) FOR YOUR APPOINTMENT

Is the purpose of this visit appointment related to?
☐ Job ☐ Auto Accident ☐ Fall ☐ Sports Injury
☐ Chronic Discomfort ☐ Wellness Care ☐ Other

If auto accident, are you claiming under Insurance Corp. of BC (ICBC)?
Yes ☐ No ☐
Date of Accident: _____
ICBC Claim #: _____
Adjustor's Name: _____
Phone #: _____

**How long** have you had this condition? _____
Is your condition getting: ☐ **worse** ☐ **better** ☐ **same**
What seems to make the condition **better**?
_____
What seems to make the condition **worse**?
_____
What have you tried that has **not worked**?
_____
Is it interfering with your:
☐ Work ☐ Sleep ☐ Daily Routine ☐ Other
Have you seen a:
☐ Chiropractor ☐ Physiotherapist
☐ Massage Therapist ☐ Acupuncturist

Date of last treatment: _____

Were you happy with the results? Yes ☐ No ☐
If **NO**, why? _____
Have you seen any other physician or healthcare professional for this complaint? Yes ☐ No ☐
If **YES**, who? _____
Date of last treatment? _____
Were X-rays or any other medical testing performed?
Yes ☐ No ☐

PLEASE COMPLETE THE FORM ON THE OTHER SIDE

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# HEALTH HISTORY

Please indicate conditions presently causing you problems, as well as conditions which were a problem in the past.

| Musculoskeletal System | Present | Past |
|---|---|---|
| Neck Problems | □ | □ |
| Jaw Problems | □ | □ |
| Upper Back Problems | □ | □ |
| Shoulder Problems | □ | □ |
| Elbow/Wrist Problems | □ | □ |
| Low Back Problems | □ | □ |
| Ankle/Foot Problems | □ | □ |
| Arthritis | □ | □ |
| Muscle Soreness | □ | □ |
| Scoliosis | □ | □ |

| Circulatory System | Present | Past |
|---|---|---|
| High Blood Pressure | □ | □ |
| High Cholesterol | □ | □ |
| Heart Condition | □ | □ |
| Aneurysm | □ | □ |
| Stroke | □ | □ |
| Varicose Veins | □ | □ |
| Bleeding Disorder | □ | □ |

| Pulmonary | Present | Past |
|---|---|---|
| Asthma | □ | □ |
| Chest Pain | □ | □ |
| Difficulty Breathing | □ | □ |
| Persistent Cough | □ | □ |

| Genito-Urinary System | Present | Past |
|---|---|---|
| Painful Urination | □ | □ |
| Excessive Urination | □ | □ |
| Scanty Urination | □ | □ |
| Discolored Urine | □ | □ |

| Nervous System | Present | Past |
|---|---|---|
| Headaches | □ | □ |
| Loss of feeling | □ | □ |
| Numbness | □ | □ |
| Dizziness | □ | □ |
| Fainting | □ | □ |
| Loss of balance | □ | □ |
| Confusion | □ | □ |
| Depression | □ | □ |
| Forgetfulness | □ | □ |
| Fatigue | □ | □ |
| Anxiety | □ | □ |

| Allergies | Present | Past |
|---|---|---|
| Seasonal | □ | □ |
| Hay Fever | □ | □ |
| Sinus Pain | □ | □ |
| Drug | □ | □ |
| Food | □ | □ |

Other: _____

| Gastrointestinal System | Present | Past |
|---|---|---|
| Poor Appetite | □ | □ |
| Excessive Hunger | □ | □ |
| Abdominal Pain | □ | □ |
| Excessive Thirst | □ | □ |
| Nausea/Vomiting | □ | □ |
| Diarrhea | □ | □ |
| Constipation | □ | □ |
| Bloody/Black Stool | □ | □ |
| Liver/Gallbladder trouble | □ | □ |
| Weight Trouble | □ | □ |
| Ulcer | □ | □ |

| Systemic | Present | Past |
|---|---|---|
| Diabetes | □ | □ |
| Hypoglycemia | □ | □ |
| Epilepsy | □ | □ |
| Rheumatoid | □ | □ |
| TB | □ | □ |
| HIV/AIDS | □ | □ |
| Cancer: Stage: _____ | □ | □ |
| MS | □ | □ |
| Parkinson's | □ | □ |
| Thyroid Problems | □ | □ |

Other:

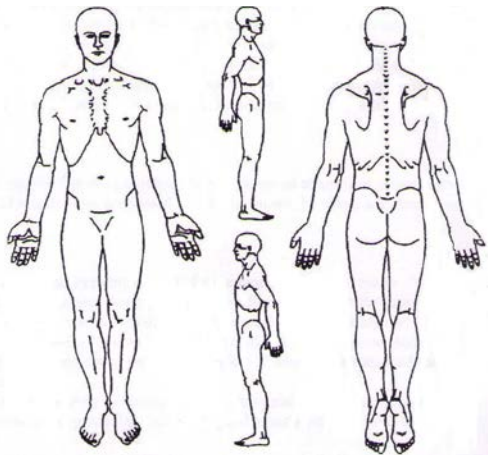
| Ear, Eyes, Nose, Throat | Present | Past |
|---|---|---|
| Eye Problems | □ | □ |
| Vision Problems | □ | □ |
| Ear Discharge | □ | □ |
| Ear Pain | □ | □ |
| Ear Ringing | □ | □ |
| Hearing loss | □ | □ |
| Sore Throat | □ | □ |
| Hoarseness | □ | □ |
| Enlarge Glands | □ | □ |

| Female | Present | Past |
|---|---|---|
| Vaginal Discharge | □ | □ |
| Vaginal Bleeding | □ | □ |
| Hormonal contraceptives | □ | □ |
| Menstrual pain | □ | □ |
| Irregular cycle | □ | □ |
| Menopausal? | Yes □ | No □ |
| Pregnant? | Yes □ | No □ |

Due Date? _____

| Male | Present | Past |
|---|---|---|
| Prostate Problems | □ | □ |

*Mark the areas of your body with an X where you feel pain or discomfort*



Orthopedic metal implants?
Yes □ No □
Explain:_____

Recent cortisone injections?
Yes □ No □
Explain:_____

Had any broken bones?
Yes □ No □
Explain:_____

Been struck unconscious?
Yes □ No □
Explain:_____

Any significant accidents or injuries?
Yes □ No □
Explain:_____

Had surgery?
Yes □ No □
Explain:_____

Had any major strains or sprains?
Yes □ No □
Explain:_____

Use orthotics, heel lifts, or insoles?
Yes □ No □
Explain:_____

Scale from 1 (not painful) to 10 (very painful); please indicate your pain level?

_____

The information on this form is true to the best of my memory and I consent to further evaluation as deemed appropriate by the Practitioner. I have agreed to receive email appointment reminders, newsletters, and other correspondence relating to my treatment(s) at e.volve health and wellness.

<u>24 HOUR CANCELLATION FEE WILL APPLY IF PATIENT DOES NOT CALL TO CANCEL 24 HOURS PRIOR TO APPOINTMENT</u>.

*Patient Initials:* _____

Patient Signature: _____ Date: _____