CONFIDENTIAL PATIENT HISTORY FORM

2-1890 Ambrosi Rd, Kelowna, BC V1Y 4R9 P:778.478.0548 F: 778.478.0847

Name _____ **Birthdate** _____

Address _____ **Family Doctor** _____

_____ Phone _____

Postal Code _____ **Referring Professional** _____

Phone (home) _____ Phone _____

(cell) _____ **Care Card #** _____

(work) _____

Email _____

_____

Occupation _____

ICBC or WCB? Claim # _____

ACTIVE CLAIM - Please inform reception. We require Dr. referral, claim#, adjuster's name & date of injury.

How did you hear about our clinic? _____

Please circle	1 = poor		5 = excellent		
Quality of sleep	1	2	3	4	5
Energy level	1	2	3	4	5
Eating habits	1	2	3	4	5
Stress level	1	2	3	4	5
Exercise habit	1	2	3	4	5

Please list activities, sports, hobbies

_____

_____

_____

_____

_____

Medical History:

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Radiotherapy/Chemotherapy (in past 6 months)
- ☐ Cardiac Pacemaker
- ☐ Angina
- ☐ Other Heart Problems
- ☐ Pregnant
- ☐ Steroids
- ☐ Blood Thinners
- ☐ Sudden Weight Loss
- ☐ Change in Bowel/Bladder Function

Medication: Please list all current medication

_____

Allergies:

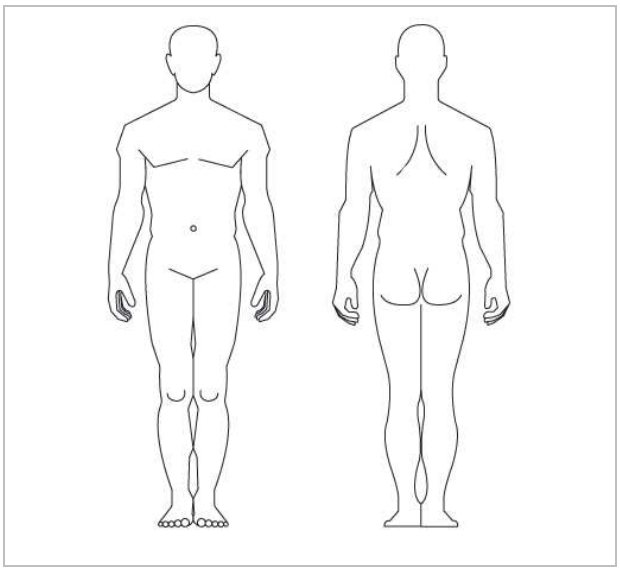
_____

Have you ever been hospitalized, any major accidents, illnesses or surgeries?

_____

Continue over…

Please describe your current condition & symptoms.



How long have you had this condition? _____

How did it start? _____

What aggravates it? _____

What relieves it? _____

Conditions:

- ☐ Headaches
- ☐ Nausea
- ☐ Double Vision
- ☐ Eye Disturbances
- ☐ Loss of Consciousness
- ☐ General Malaise
- ☐ Pins & Needles
- ☐ Numbness
- ☐ Dizziness/Light-headed
- ☐ Sleep Disturbances
- ☐ Difficulty Speaking
- ☐ Difficulty Swallowing

Investigations: Have you had any of the following for this issue…

- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ US Scan
- ☐ Other _____

Pain Behavior: Is your pain…

- ☐ Improving
- ☐ Constant
- ☐ Worsening
- ☐ Intermittent
- ☐ The Same

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist, we require 24 hour notice of cancellation or full payment will be charged.

I authorize the clinic and its associated therapist to collect my personal and medical information as documented above and give permission for the clinic to call or leave messages regarding appointments at any of the contact numbers I have provided. I authorize the clinic and its associated therapist to communicate with my referring MD as deemed necessary for my treatment. I understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: **Date:**