

PERSONAL AND FAMILY HEALTH HISTORY

Today's date: _____

Name: _____
last first middle

Marital status: S M W D

Address _____
street city postal code

Gender M F Age _____ Date of Birth _____

Spouse _____ Children _____

Method for Appointment Reminders:

Home Phone _____

Cell Phone _____

Email _____

Work Phone _____

Occupation _____ Employer _____

How did you hear of us? _____ Medical Doctor _____

When was your last adjustment? _____ By Whom? _____

Do you need printouts for Extended Health No _____ Yes _____

Are you claiming Worker's Compensation? No _____ Yes _____ Claim # _____

Are you claiming under ICBC? No _____ Yes _____ Claim # _____

Family Health: Is there a family history of: Arthritis Cancer Diabetes Strokes
 Heart Disease High Blood Pressure Other _____

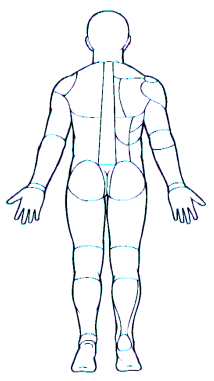
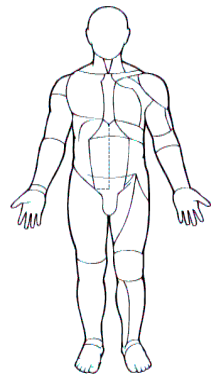
PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH AND WELLBEING

I am only concerned about relief of a particular symptom

I am concerned about relief of a particular symptom, and preventing its return

I am here for preventative wellness care

Please clarify areas of concern:



PERSONAL HISTORY

**THE HUMAN BODY IS DESIGNED TO EXPRESS HEALTH AND FUNCTION NORMALLY.
 HOWEVER, EVENTS MAY OCCUR IN LIFE, WHICH CAN INTERFERE WITH THIS NATURAL ABILITY.
 THIS INTERFERENCE IS COMMONLY THE RESULT OF VERTEBRAL SUBLUXATIONS.
 STRESS THAT MAY BE PHYSICAL, CHEMICAL OR EMOTIONAL
 MAY CAUSE THESE SUBLUXATIONS.**

**THE PRACTICE OF CHIROPRACTIC IS BASED ON THE LOCATION AND REDUCTION OF NERVE
 SYSTEM INTERFERENCE CAUSED BY THE VERTEBRAL SUBLUXATION.**

PLEASE TELL US ABOUT ANY STRESS UP TO THE PRESENT:
check any that apply

- | | |
|--|----------------|
| <input type="checkbox"/> Stress at birth (premature / forceps) | Explain: _____ |
| <input type="checkbox"/> Allergies / Asthma | _____ |
| <input type="checkbox"/> Digestive problems | _____ |
| <input type="checkbox"/> Auto injury | _____ |
| <input type="checkbox"/> Work injury | _____ |
| <input type="checkbox"/> Sports injury | _____ |
| <input type="checkbox"/> Work stress | _____ |
| <input type="checkbox"/> Family / Home stress | _____ |
| <input type="checkbox"/> Prescription drug use | _____ |
| <input type="checkbox"/> Non-prescription drug use | _____ |
| <input type="checkbox"/> Hospitalizations | _____ |
| <input type="checkbox"/> Surgeries | _____ |
| <input type="checkbox"/> Major illnesses | _____ |
| <input type="checkbox"/> Reoccurring illness | _____ |
| <input type="checkbox"/> Limited exercise | _____ |
| <input type="checkbox"/> Poor nutrition | _____ |

Anything else: _____
