Essential
CHIROPRACTIC + WELLNESS CENTRE

Suite # 103- 4180 Lougheed Highway,
Burnaby, BC V5C-6A7
Tel. 604.293.2273 Fax.604.473.9070

PLEASE COMPLETE THE FOLLOWING INFORMATION SHEET – BOTH SIDES
(PARENTS – PLEASE COMPLETE FOR YOUR CHILD)

Today's Date:______________________________
month day year

Last Name:	First Name:	
Birthdate (mo/day/yr): / /	Age:	Marital Status: S☐ M☐ W☐ D☐
Care Card #:	Gender: M ☐ F ☐	
Occupation:	Number of children:	
Indicate Any Recent Medical Tests (within last 12 months) ? ☐ X-rays ☐ C/T or MRI Scan ☐ Bone Scan ☐ Blood Tests ☐ Heart ☐ Other?		
Emergency Contact Name:	Emergency Contact #:	
Your Present Address: Street:		
City:		
Postal Code:		
Telephone Numbers: Home:	Work:	Cell:
E-mail Addresses:		

Referred by:
- Medical Doctor ☐
- Yellow Pages ☐
- Workshop ☐
- Other Health Professional ___________ ☐
- Present Patient (NAME?)_______________ ☐
- Other ___________________(specify)

Family Doctor's Name:	City:	Phone #:

WILL YOU BE CLAIMING AGAINST :

☐ WCB? (Work Injury)	☐ ICBC? (Car Accident?)	☐ Extended Health Insurance?
HAVE YOU CONSULTED A CHIROPRACTOR BEFORE? Y ☐ N ☐		WHEN?

Please note our office is specialized in the diagnosis of a condition known as SPINAL SUBLUXATION. We do not offer to diagnose or treat any disease or condition other than spinal subluxation. Research has shown that spinal subluxation can interfere with delicate and vital nerve flow in the body. Subluxations cause severe stress and tension in muscles, organs and other tissues. Subluxations can be the cause of loss of health and vitality.

Have you heard of this condition? Y ☐ N ☐
Have you ever been evaluated for SPINAL SUBLUXATION? Y ☐ N ☐

WHAT WOULD YOU LIKE THE CHIROPRACTOR TO HELP YOU WITH?(eg:Spinal checkup? Headaches? Backpain? Wellness?)
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HOW DOES THE ABOVE AFFECT YOUR DAILY LIFE OR ACTIVITIES?
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YOU WOULD DESCRIBE YOUR HEALTH AS? ☐ **POOR** ☐ **COULD IMPROVE** ☐ **EXCELLENT**

WHAT AREAS OF YOUR HEALTH WOULD YOU LIKE TO SEE IMPROVE?

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WHAT COULD BE CAUSING YOUR PRESENT HEALTH CONCERNS? *e.g. birth process; poor posture at work or school; previous injuries; poor lifestyle habits; poor diet; poor stress or time management?*

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LIST THE TOP 3 STRESSORS IN YOUR LIFE? (eg: work, time management, relationships, money, etc.)

1.	2.	3.

IS THERE ANY HISTORY OF THE FOLLOWING IN YOU OR YOUR IMMEDIATE FAMILY? (please check):

☐ CANCER ☐ HEART DISEASE ☐ STROKE ☐ DIABETES ☐ UNEXPLAINED WEIGHT LOSS ☐ SMOKER

LIST ANY and ALL SURGERIES, OPERATIONS OR FRACTURES AND WHEN THEY OCCURRED:

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PLEASE CHECK WHICH OF THE FOLLOWING YOU HAVE EXPERIENCED IN THE PAST YEAR *(even if they do not seem related to your current problem):*

☐ Headaches/Migraines	☐ Pins & Needles in Legs	☐ Fainting	☐ Neck Pain
☐ Pins & Needles in Arms	☐ Loss of Smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Buzzing in Ears	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in Fingers	☐ Numbness in Toes	☐ Loss of Taste	☐ Upset Stomach
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension/Stress
☐ Sleeping Problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweat	☐ Sensitive Eyes	☐ Problems Urinating	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers
☐ High Blood Pressure	☐ Heartburn/Reflux	☐ Jaw/TMJ problems	☐ Shortness of Breath
☐ Other:			

CHIROPRACTIC HEALTH CARE IS A NATURAL LIFESTYLE CHOICE. PLEASE CHECK ANY OTHER NATURAL LIFESTYLE CHOICES YOU CHOOSE TO BENEFIT FROM REGULARLY: ☐ bottled water; ☐ organic foods; ☐ vitamins and supplements; ☐ regular exercise or sports; ☐ meditation/relaxation; Other ________________________________

ARE YOU TAKING ANY DRUGS? (prescription, over the counter, recreational?) Y ☐ N ☐

IF YES, PRESCRIPTION? LIST:
OVER THE COUNTER? LIST:
OTHER LIST:

ANYTHING ELSE YOU WOULD LIKE THE CHIROPRACTIC DOCTOR TO KNOW?____________________

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Date:__________________________ Patient's Name (Printed):______________________________________

Patient or Parent/Guardian Signature:____