

# HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. Thank You.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date Of Birth: \_\_\_\_\_ Care Card #: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_  
City: \_\_\_\_\_ Post. Code: \_\_\_\_\_ Phone (H): \_\_\_\_\_  
Occupation: \_\_\_\_\_ Phone (W): \_\_\_\_\_  
In Emergency, Notify: \_\_\_\_\_ Phone: \_\_\_\_\_  
How Did You Discover Our Office: \_\_\_\_\_  
Previous Chiropractor: \_\_\_\_\_  
Date Of Last Chiropractic Adjustment: \_\_\_\_\_  
Family Medical Doctor: \_\_\_\_\_ Date Of Last Physical: \_\_\_\_\_  
Is this an ICBC Claim? YES / NO Is this a WCB Claim? YES / NO  
If YES, your claim #: \_\_\_\_\_ If YES, your claim #: \_\_\_\_\_

WHAT IS THE MAIN PROBLEM YOU WOULD LIKE US TO ADDRESS?

When did you first notice any symptoms? \_\_\_\_\_  
Have you experienced these symptoms before? \_\_\_\_\_ Is this condition getting  
**BETTER**, getting **WORSE** or **STAYING THE SAME?** (circle one)  
Have you been given a **diagnosis** for this condition by another physician? YES / NO  
If YES, what was the diagnosis? \_\_\_\_\_  
Have you received any **previous treatment** for this condition? YES / NO  
If YES, by **WHOM**, and did it **HELP?** \_\_\_\_\_  
Is your present condition the result of a single **traumatic event?** YES / NO  
If YES, please describe in detail what happened: \_\_\_\_\_

## SYMPTOMS OF THE PRESENT CONDITION:

Draw in your face

Mark the area(s) on the diagrams where you feel the described sensations.

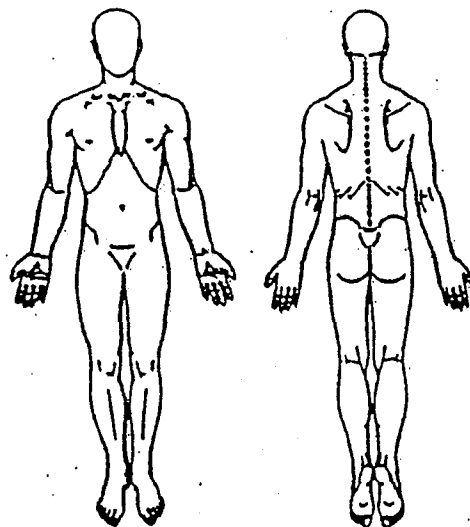
Use the appropriate symbols.

Please include all affected areas, including regions of radiating pain, numbness and tingling.

Sharp pain: XXXXXX

Dull, aching: 000000

Numbness or pins & needles: /////



\*\*Other sensations: please mention to the doctor during the initial examination.

7

Make a vertical mark on the line below, indicating the intensity of your pain today:  
NO PAIN |-----| UNBEARABLE PAIN

Does the pain radiate from the area of your primary complaint? YES / NO

If YES, where does it radiate to? \_\_\_\_\_

Is the pain constant? \_\_\_\_\_ If the pain comes and goes, how often do you experience the symptoms? \_\_\_\_\_/day, \_\_\_\_\_/week, \_\_\_\_\_/month, \_\_\_\_\_/year?

Is the pain worse in the MORNING, AFTERNOON or EVENING? (circle if applicable)

Does the pain prevent you from sleeping? \_\_\_\_\_ If YES, how much per night? \_\_\_\_\_

Do you regularly sleep on your STOMACH, SIDE or BACK? (circle one if applicable)

What makes your condition feel worse? (please circle)

standing sitting lying walking running jumping bending twisting

lifting coughing sneezing bowel movements getting up from a chair

other: \_\_\_\_\_

What makes your condition feel better? (please circle)

rest ice heat stretching exercising medication other: \_\_\_\_\_

### MEDICAL HISTORY:

Have you ever been in any traffic accidents? \_\_\_\_\_

YES / NO

If YES, please describe: \_\_\_\_\_

Have you experienced any broken bones? \_\_\_\_\_ Which ones? \_\_\_\_\_

Have you had any surgery? \_\_\_\_\_ If YES, describe: \_\_\_\_\_

Have you, or anyone in your family, experienced any of the following conditions?

CONDITION:	YOU:	FAMILY MEMBER:	DESCRIBE:
<input type="checkbox"/> Cancer	_____	_____	_____
<input type="checkbox"/> Arthritis (rheumatoid/osteo)	_____	_____	_____
<input type="checkbox"/> Diabetes (Type I/II)	_____	_____	_____
<input type="checkbox"/> Heart conditions	_____	_____	_____
<input type="checkbox"/> Asthma/emphysema	_____	_____	_____
<input type="checkbox"/> Stroke	_____	_____	_____
<input type="checkbox"/> Osteoporosis	_____	_____	_____
<input type="checkbox"/> Irregular blood pressure	_____	_____	_____
<input type="checkbox"/> Nerve disorders	_____	_____	_____
<input type="checkbox"/> Epilepsy	_____	_____	_____

Are you taking any medications? If so, what are they? \_\_\_\_\_

Do you smoke cigarettes/cigars? \_\_\_\_\_ If YES, how many per day? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If YES, how much per week? \_\_\_\_\_

What do you do for exercise? \_\_\_\_\_

How often do you exercise per week? \_\_\_\_\_

Have you experienced any stressful events lately? \_\_\_\_\_ If so, describe below:

\_\_\_\_\_

If there is any other information regarding your present condition that you think would help us, please mention below: \_\_\_\_\_

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# PATIENT PAST HISTORY FORM

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional      F = Frequent      C = Constant

**O   F   C**

- allergy
- chills
- convulsions
- dizziness
- fainting
- fevers
- headaches
- loss of sleep
- nervousness
- depression
- neuralgia
- numbness
- sweats
- loss of weight
- tremors

**MUSCLE & JOINT**

- arthritis
- bursitis
- foot trouble
- hernia
- low back pain
- neck pain
- neck stiffness
- pain between shoulders

**RESPIRATORY**

- chest pain
- chronic cough
- difficulty breathing
- spitting blood
- throat phlegm
- wheezing

**EYES, EARS,  
NOSE & THROAT**

- colds
- crossed eyes
- deafness
- dental decay
- asthma
- ear aches
- ear discharges
- ear noises

**O   F   C**

- sinus infections
- enlarged glands
- enlarged thyroid
- sore throats
- tonsillitis
- eye pain
- failing vision
- far sighted
- gum trouble
- hay fever
- hoarseness
- nasal obstruction
- near sighted
- nosebleeds

**CARDIO-VASCULAR**

- rapid heart beats
- slow heart beat
- swelling of ankles
- hardening of arteries
- high blood pressure
- low blood pressure
- pain over heart
- poor circulation

**GASTRO INTESTINAL**

- excessive hunger
- burping or gas
- liver trouble
- colitis
- colon trouble
- constipation
- diarrhea
- difficult digestion
- distension of abdomen
- stomach pain
- gall bladder trouble
- hemorrhoids
- intestinal worms
- jaundice
- poor appetite
- nausea
- vomiting
- vomit blood

**O   F   C**

**SKIN**

- boils
- bruise easily
- dryness
- hives or allergy
- itching
- skin rash
- varicose veins

**GENITO-URINARY**

- ~~bed~~ wetting
- blood in urine
- frequent urination
- loss control urine
- kidney infection
- painful urination
- prostate trouble
- pus in urine
- smell of urine

**PAIN OR NUMBNESS IN:**

- shoulders
- arms
- hands
- hips
- legs
- knees
- ankles
- feet
- painful tail bone
- sciatica
- swollen joints

**FOR WOMEN ONLY**

- cramps
- heavy flow
- light flow
- irregular cycle
- painful cycle
- discharge
- sore breasts

Menopausal:     Yes     No

Last menstration date:

Pregnant:     Yes     No  
 due date: \_\_\_\_\_



**Informed Consent to Chiropractic Adjustments and Care**

Doctors of Chiropractic, medical doctors, and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

- a) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal or extremity adjustments.
- b) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairments, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote.
- c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments, although no scientific study has ever demonstrated such injuries were caused, or may be caused, by spinal adjustments or chiropractic treatment.
- d) It has been our experience that many conditions are the result of, or are compounded by, injuries to the muscle that stabilize the involved area. Your therapy may include treatment of these muscles which may include, but are not limited to, the pectoralis minor, pectoralis major, serratus anterior and the intercostal muscles (anterior chest muscles), the gluteus maximus, medius, and piriformis muscles (buttocks area), and/or the hip flexors, adductors, and hamstring muscles (groin area). Treatment of these muscles will necessitate touching, work on, and palpation of these areas.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be a highly effective treatment for spinal pain, headaches, and many soft tissue conditions. Chiropractic care contributes to your overall health and wellness. The risk of injuries or complications from chiropractic treatments is substantially lower that associated with many medical or other allied health treatments and procedures given for the same symptoms.

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I acknowledge that I have read and discussed, and/or have had the opportunity to read and discuss with my chiropractor, **Dr. John Dang or Dr. Glen Thomson**, the nature and purpose of chiropractic treatment in general, my treatment in particular, including spinal adjustments, and the contents of the Consent form.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustments, extremity adjustments, and any other adjunctive therapy and technique. I intend this consent to apply to all my present and future chiropractic care.

\_\_\_\_\_  
Patient's Name (please print)

\_\_\_\_\_  
Signature of Patient (or parent/guardian)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Witness



**OFFICE POLICY REGARDING FEES AND INSURANCE COVERAGE FOR:**

**Chiropractic**

**DR. JOHN DANG, BSc, DC & DR. GLEN THOMSON, DC**

Our fee policy is a reflection of the specialized procedures incorporated in this office and allows us to give what we feel to be the highest quality of chiropractic care.

Your insurance policy is a contract between you and your insurance company. **This office does not do direct billing nor collect payment from your extended health insurance company**, with the exception of ICBC & MSP.

<b>OFFICE FEE SCHEDULE</b>	<b>Extended Health</b>	<b>(*) MSP Premium Assistance</b>	<b>ICBC</b>
Initial Visit Consultation & Examination	\$80.00	\$57.00	\$57.73
Report Visit	\$60.00	\$37.00	-
Subsequent Visit	\$45.00	\$22.00	\$27.65
Laser Therapy (Cold)	\$50.00 / 30 mins session		

**(\*) The Medical Service Plan of BC will provide some subsidy for those patients approved for premium assistance. Effective January 1<sup>st</sup> 2002, the maximum number of visits is 10 per calendar year and is cumulative with other health practitioners**

**Payment for all services is due at the time of treatment**

We appreciate 24 hrs notice for cancellation or rescheduling of appointments.

**Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_  
(parent or guardian if applicable)